TIP 13—Contents

Exhibits and Figures

What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then communicated to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Chair (or Co-Chairs) for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment used in public and private programs recognized for their provision of high quality and innovative treatment.

One of the objectives being discussed in the AOD treatment field today is the establishment of standardized patient placement criteria (PPC) for use throughout the field. PPC can be used to assess the severity of clients' problems, place them in appropriate levels of care, and facilitate movement through the continuum of treatment services. This TIP will help readers understand what PPC are and learn from the experiences of others who have helped develop currently used criteria. It also lays the groundwork for a concerted effort to develop national uniform patient placement criteria (UPPC). The many advantages of adopting UPPC are discussed in this TIP, along with "how to" suggestions and strategies for developing national support for UPPC.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) 800-729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. I am grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

Susan L. Becker
Director of State Programs
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Chapter 1—Introduction

In recent years, the alcohol and other drug (AOD) abuse treatment field has begun the process of standardizing patient placement criteria (PPC). The goal is to establish *uniform patient placement criteria* (UPPC), accepted by all providers in the field, that can be used to accurately assess the severity of a client's problems in three areas: medical, psychological, and social. Carefully developed UPPC will lead to effective placement of clients in appropriate levels of care. Such criteria can also be used as a basis for making decisions about moving clients through the continuum of treatment services as treatment progresses or relapses occur.

The Development of UPPC

In developing this Treatment Improvement Protocol (TIP), Federal officials and national professional association representatives met with the chairs of the consensus panel to advise them about its content. There was considerable discussion regarding the role of the panel in developing "the definitive set" of patient placement criteria. Ultimately, it was decided that the nature of the TIP development process, as well as time constraints, would not allow for analysis and discussion of all the input that would be necessary to develop UPPC. Before UPPC could be developed, existing criteria and the experiences of those who have implemented them would have to be assembled and examined.

The purpose of the consensus panel and of this TIP, therefore, is not to write these uniform patient placement criteria, but to lay the groundwork for developing them. A wide variety of people are interested in the current use of PPC and their evolution; these "stakeholders" and their interests are enumerated in this TIP. It was written also to inform readers of the sets of criteria and issues in the development, adoption, implementation, and ongoing improvement of patient placement criteria. States just beginning to consider patient placement criteria can use this TIP to learn from the experiences of others and avoid pitfalls. For those further along, the TIP can provide a vision of future directions in the challenging but necessary move toward national uniform patient placement criteria.

The purpose of this TIP is not to write uniform patient placement criteria, but to lay the groundwork for developing them.

Assuming UPPC are developed with the broadest possible input and are based on research and evaluation findings, they can be used to help ensure that:

- The client's specific needs will be identified and a level of care will be chosen to fully address those needs
- A method is in place for continually improving the effectiveness of assessment, placement, and treatment.

Advantages of UPPC

The many advantages of adopting UPPC will be discussed in detail throughout this TIP and are summarized here.

- A common lexicon describing the dimensions of assessment and the components of the continuum of care can enable clinicians to consult about clients or program characteristics without confusion.
- Uniform criteria can provide a common basis for study and continual improvement, not only of the criteria themselves, but also of the services provided in response to particular criteria.
- UPPC can help alleviate the high cost of undertreatment by ensuring that patients get *all* the treatment they need, based on continued stay criteria rather than arbitrary monetary or time limitations.
- UPPC can alleviate the high cost of overtreatment by ensuring that patients get *only* the treatment they need, based on assessed needs and established criteria.
- Common definitions of levels of care, common standards of assessment, and common standards for continued stay and discharge can establish the same framework for public and private programs.

Nearly all AOD abuse treatment is influenced by some form of managed care in its broadest sense. Virtually no payment system-public or private-is free from eligibility, admission, or discharge criteria. Private payment systems sometimes limit the duration of treatment or number of admissions, which leads to inadequate treatment of severely impaired consumers. Public payment systems may limit treatment to *only* severely impaired consumers, prohibiting access to service for individuals when their problems are less complex. Lack of a single, consistently applied set of criteria has led to gaps in service in both public and private systems.

The need for patient placement criteria arises from the desire of professionals involved in the provision of AOD treatment services to improve the quality and appropriateness of services. This desire manifests itself in efforts to align the duration of treatment and level of care with the client's identified needs.

Various assessment instruments and interview guides have been developed to assist clinicians in assessing the broad range of client needs. The information gathered through this process helps determine the level of care appropriate for the client. Continued assessment dictates changes in the level of care. Patient placement criteria provide a link between assessment data and placement decisions. Any guidelines that provide this link or start with a specific level of care can be considered patient placement criteria. Perhaps the most recognized are those used by private managed care firms, but certainly individual treatment programs have guidelines that place clients in a level of care, identify the need for transition to another level, and define completion of treatment. Moving from a proliferation of varying sets of patient placement criteria to uniform criteria would have some major advantages, which are discussed in this TIP.

Challenges

As the advantages of adopting UPPC become apparent, the question may be asked: Why hasn't some form of patient placement criteria been adopted by every funder, every treatment provider, and every State? What are the barriers to development?

Bringing consistency to placement decisions has a number of advantages, but the development of the criteria presents challenges. In some situations, the advantages are not recognized. In other situations, the task of implementation is daunting because of limited resources, geography, multiple funding systems, or separate treatment systems for public and private clients. The tasks of writing new criteria or sorting through the proliferation of existing criteria are overwhelming. This TIP addresses these and other barriers, so that movement toward an accepted set of placement criteria is furthered.

The Role of the States

The discussion of UPPC for AOD abuse treatment has largely taken place among clinicians and treatment providers, with limited attention given to the implementation of UPPC as public policy. In contrast, this TIP is intended to be useful to a variety of audiences:

- Single State agency (SSA) administrators, who are responsible for establishing policy and for the funding and oversight of AOD abuse treatment programs
- Other State authorities responsible for regulating treatment and managed care organizations
- AOD abuse treatment clinicians, including substance abuse counselors, social workers, psychiatrists and other physicians, nurses, psychologists, employee assistance professionals, and others who provide screening, assessment, and referral services
- Managed care organizations, third-party payers, utilization reviewers, benefit managers for employer-based health plans, and other purchasers of service.

However, this TIP is addressed primarily to the SSAs, which are key to the standardized implementation of patient placement criteria because:

- SSAs participate in the funding of treatment for thousands of patients each year who do not have access to private or third-party payment.
- As States move toward managed care for the Nation's approximately 33,000,000 Medicaid clients, SSAs are important participants in the discussion on substance abuse services for these clients.
- Many States are moving ahead with healthcare reform, with SSAs participating in decisions about substance abuse benefits for the working poor in State-organized or State-subsidized health plans.
- National healthcare reform, if it includes UPPC at all, may leave placement criteria issues to the discretion of the States.
- SSAs write the licensing regulations for treatment providers, which can facilitate or impede the use of effective patient placement criteria.

Therefore, this TIP broadens the discussion to include the implementation of patient placement criteria and related public policy issues at State and national levels.

Origins of This TIP

It is widely believed that placing patients in levels of care appropriate to their needs will improve treatment outcomes and lead to more efficient use of funds. Yet full consensus has not been

reached on which criteria to use, despite the integration of two national sets of criteria into the American Society of Addiction Medicine's (ASAM) criteria, which were published in 1991. Recognizing that a broader consensus must be developed by all significant stakeholders, ASAM convened a roundtable discussion conference in November 1991. The goal was to assess support for national patient placement criteria and to determine methods for gaining consensus in the field.

This conference led to the establishment in November 1992 of the Coalition for National Clinical Criteria, which held two subsequent meetings. The Center for Substance Abuse Treatment (CSAT) recognizes that it can play a useful catalytic role in the effort to reach consensus on UPPC. Aware that State alcohol and other drug abuse treatment organizations (and others) saw the need to develop more effective and comprehensive systems of care in a managed care and healthcare reform environment, CSAT sponsored the development of this TIP.

The ASAM criteria have become the most widely distributed, implemented, discussed, and reviewed criteria available. Several States have adapted the ASAM PPC for use with public providers. For these and other reasons, the ASAM PPC are referenced in this TIP as a basis of comparison. They are not perfect, nor are they universally accepted. However, no other set of criteria reviewed for this TIP demonstrated significant advantages over the ASAM criteria.

The UPPC discussed throughout this TIP do not yet exist. While the ASAM PPC provide an important starting point, they do not represent the UPPC envisioned by this consensus panel. Much work is needed to develop criteria that adequately address the needs of all populations within a complete range of treatment programs. The UPPC that are ultimately developed may be a significantly revised version of the ASAM criteria. On the other hand, the developed criteria may be entirely new, sharing with the ASAM PPC only the essential principles of development by consensus, multidimensional assessment, continuity of care, and a common language.

Overview of the TIP

Chapter 2-The Role of PPC in a Managed Care Environment. This chapter, initially written by David Mee-Lee, M.D., and revised for this TIP, describes the challenge of transitioning to new cost-conscious systems of care. While UPPC alone cannot produce this transition, this chapter puts in perspective the role of UPPC in diagnosis, placement, matching to specific modalities and strategies, and efficient utilization of healthcare resources.

Chapter 3-Critique of Existing Criteria. This chapter provides a detailed analysis of the ASAM criteria and examines other public and private criteria currently in use. With strengths and weaknesses of the criteria identified, recommendations are then made for interim steps to be taken until a redesigned set of uniform criteria can be developed. Recognizing that placement criteria alone do not efficiently match patients to treatment, directions are discussed that would allow an increased assessment-based match to individualized treatment components.

Chapter 4—Building Support for Adopting UPPC. Chapter 4 describes how the implementation of UPPC can provide a framework that will enhance patient access to the full range of treatment services. Once established, UPPC will have the potential to improve assessments and individual

treatment plans; provide economic benefits; and establish a common language for multidisciplinary service providers, payers, policymakers, and other interested parties.

Chapter 5—Implementation Strategies. This chapter addresses the basic decisions necessary for implementation of UPPC. Important considerations include the issue of tying UPPC to licensing requirements and treatment funding, the relationship between UPPC and the actual availability of treatment resources, and the way in which wraparound services broaden the concept of "medical necessity." Factors to consider when making placement decisions for special populations are explored. This chapter also informs the reader of the relationship between eligibility criteria and patient placement criteria. Elements and goals of assessment are delineated and staff and training needs are identified. There is a detailed discussion of the strengths and weaknesses of the settings in which assessment takes place. Finally, several useful assessment instruments and tools are identified.

Chapter 6—Future Directions: National Implementation and New Research Opportunities. This chapter discusses the process of developing widespread support for UPPC on a national level and suggests strategies for implementing them. Several immediate tasks are outlined that are necessary to overcome the barriers to acceptance of UPPC by the alcohol and other drug abuse treatment system and by stakeholder groups. Recommendations are presented for the formation of a national advisory panel to guide the consensus-building, implementation, and research process and to play a continuing role in the refinement of UPPC. The future impact of UPPC on assessment, treatment, and outcomes monitoring is described here, as UPPC may improve research and lead to quality improvement. Finally, the role of UPPC in healthcare reform is discussed.

Chapter 7—Ethical and Legal Issues. In Chapter 7, the basic ethical principles that relate to AOD abuse treatment are discussed, as well as legal issues that may arise. Once UPPC are in place, there will be strong supportive documentation confirming the treatment provider's clinical judgment and defining clearly what is meant by medical necessity. Uniform patient placement criteria, if they are developed according to the consensus-building process outlined in this document, will represent the opinions of AOD abuse treatment providers from many disciplines. The case is made that these criteria may be viewed by courts as reflecting generally accepted medical practice, especially if the criteria are widely used.

Appendix A is a list of references cited in the TIP.

Appendix B lists resources that might be useful to programs or systems seeking to create or adapt patient placement criteria. Assessment instruments are described, as well as software packages to aid clinical management of patients. For readers who wish to examine existing criteria in more detail, Appendix B provides information on obtaining criteria sets from various States and private organizations. The final section is a brief annotated bibliography of materials related to managed care and healthcare reform.

Appendix C is a glossary of terms used in the TIP.

Appendix D lists the names of persons who attended the Federal resource panel in the early stages of development of the TIP, and Appendix E lists the names of experts from across the country who participated in the field review of the TIP.

Chapter 2—The Role of PPC in a Managed Care Environment

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Concern about healthcare costs, coupled with the perception that much care is unnecessary or provided inefficiently, has given rise to new techniques for managing health benefits and holding clinicians accountable for services provided (Institute of Medicine, 1989). Using these techniques means that access to quality care must be carefully balanced with the demands of cost containment through a process known as managed care.

Initially, managed care was associated with medical treatment in the private sector. But with the push for national healthcare reform and the States' move toward providing managed care for patients receiving care in the public sector, the boundary between "public" and "private" healthcare is becoming blurred. The substance abuse field has not been exempt from having to adapt itself to managed care approaches now in place or being established in numerous States.

There is an urgent need for the addiction treatment field to "retool" by finding more efficient and cost-effective ways to provide care by protecting the quality of and access to addiction treatment, and by fully integrating research findings into practice.

The Transition to Cost-Conscious Treatment

Outside the United States, one finds a wide variety of treatment modalities, models, and settings. Within the U.S. (in the private-sector addiction treatment field), there has been just one major approach to treatment, based on the Alcoholics Anonymous 12-step philosophy and the fixed length of inpatient stay pioneered in Minnesota. This treatment approach, with its inpatient treatment philosophy (Institute of Medicine, 1990), has been more commonly used for treating alcohol and other drug abuse than any other approach. This is the treatment model that has been

usedin a "one size fits all" approachfor almost all patients who met the criteria for the treatment of alcohol or other drug addiction. The Minnesota model has been significantly revised since its development in the late 1940s and 1950s, and other models have come into existence to choose from. However, the Minnesota model has remained the dominant type of treatment (Institute of Medicine, 1990).

In the public sector, there has been a wider variety of models and settings covering both inpatient and outpatient programs. This variety arose from a multitude of perspectives, ideologies, and funding initiatives, rather than from a deliberate, cost-conscious systems development strategy.

Today, in the alcohol and other drug abuse treatment (AOD) field, there is a movement toward using a variety of treatment models to ensure access to quality treatment and conserve healthcare

resources. Now clinicians must focus on matching patients to appropriate, specific treatment, rather than on placing patients in established programs. The success of clinically driven treatment depends on the importance of an accurate diagnosis. However, it is not only a diagnosis of addiction, but also of the severity of addiction, that must determine the kind of treatment an individual patient should receive. This determination can result in: placement of patients in the correct level of care, movement to less intensive or more intensive levels when appropriate, and matching patients individually to a variety of treatment modalities at all levels of care.

Implicit in this scenario is the existence of many types of treatment programs, such as narcotic addiction treatment, and outpatient and residential settings within a community. Also implicit is the growth of a variety of treatment approaches creatively developed to address underserved populations and less than adequate outcomes. Uniform patient placement criteria (UPPC) can promote the comparison of research findings, just as common diagnostic criteria in the *Diagnostic and Statistical Manual* (DSM) have allowed for coherent research and new knowledge by providing common definitions of psychiatric diagnoses. UPPC need not stifle creativity. They can allow a common base and starting point on which to establish research, build, and improve.

Development of Patient Placement Criteria

Over the last 10 years, several important models of patient placement criteria have been developed. In 1981, the Minnesota legislature asked the commissioner of human services (under whom the State authority on alcohol and drug abuse is placed) to establish criteria for use in determining the appropriate level of chemical dependency care for public assistance recipients. These criteria were developed in 1985 by a 23-member advisory committee, and drafts were distributed throughout the treatment field for comment.

The addiction treatment field needs:

- **Uniform criteria to guide proper patient placement**
- **Practice guidelines to promote the establishment of effective individualized treatment modalities**
- **Outcomes data to continually improve both the criteria and the guidelines**

In 1986, two groups, the Northern Ohio Chemical Dependency Treatment Directors Association in Cleveland and the National Association of Addiction Treatment Providers (NAATP), worked on criteria, and their efforts resulted in the publication of criteria for a continuum of care that attracted national attention. In 1989, NAATP joined forces with the American Society of Addiction Medicine (ASAM). These organizations built criteria based on a review of the literature and on 2 years of work by two task forces, whose members included addiction treatment specialists such as counselors, psychologists, social workers, and physicians. These task forces integrated and revised the Cleveland Criteria of the Northern Ohio Chemical Dependency Treatment Directors Association (Hoffmann et al., 1987) and the NAATP Criteria

(Weedman, 1987). In the interests of the field, both organizations agreed to have their PPC superseded by the third national criteria document produced by ASAM.

Thus, in March 1991, the American Society of Addiction Medicine published *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* (Hoffmann et al., 1991). These criteria for admission, continued stay, and discharge were described in terms of four levels of care, for both adults and adolescents. However, the ASAM criteria were not as applicable to publicly funded programs as to hospitals, practices of private practitioners, group practices, or other medical settings. Therefore, some States supplemented or adapted ASAM criteria. Massachusetts, for example, developed criteria for outpatient counseling, detoxification services, youth residential treatment, and methadone treatment, using the assessment dimensions, format, and structure of the ASAM criteria as a basis.

Some third-party payers and managed care organizations have developed their own sets of patient placement criteria. Until recently, these criteria were not readily available to treatment providers due to concerns that providers would slant patient information to achieve more favorable utilization management decisions. There has also been claim to the proprietary nature of the various sets of criteria. However, with increasing interest in the accreditation of managed care organizations, sets of patient placement criteria and guidelines are now more widely available.

Assessment Follows Theory

When almost everyone diagnosed with AOD abuse received the same course of treatment, there was little need for careful assessment. The course of treatment varied from program to program, depending on ideology and length of stay, but within the program there was little variation from patient to patient. "Assessment" was, in actuality, the paperwork necessary to minimally meet licensure and accreditation standards.

Attitudes about assessment across the country are important. What we believe about the causes and consequences of addiction shapes the assessment and, in turn, the treatment prescribed. The many beliefs about assessment must give way to a common standard. If the addiction field is to uniformly offer quality, accessible care at reasonable cost, some agreement must be reached among the various cognitive, theoretical, and geographic styles of assessment. The biopsychosocial definition of addiction provides a framework for making such agreement possible.

Biopsychosocial Perspective On Addiction

Donovan and Wallace have articulated a biopsychosocial model in addictive behaviors (Donovan, 1988; Wallace, 1990). Such a model helps in assessing the many clinical presentations in addiction treatment from biological, psychological, and social perspectives.

Understanding addiction as a biopsychosocial illness in its origins, expression, and treatment has four important results. Such an understanding:

1. Promotes the integration of different perspectives of the illness
2. Explains and preserves common clinical dimensions
3. Necessitates multidimensional assessment
4. Promotes effective matching of the patient with individually prescribed treatment.

Biopsychosocial Assessment

The biopsychosocial model as a broad, inclusive umbrella allows clinicians to focus on the assessment of overall clinical severity. As with the treatment of other disorders, the severity of the addiction should determine the type and intensity of treatment.

When a clinician tries to do meaningful assessment of clinical severity, there is not full agreement on the best methods for assessment. In the case of alcoholism, some researchers focus on "a) severity of current or cumulative consequences of drinking, b) level of alcohol consumption, c) severity of current or cumulative signs of alcohol dependence, or d) problem duration" (Miller and Hester, 1986).

The Addiction Severity Index (ASI) broadens severity assessment to patients using or abusing drugs other than alcohol and focuses on seven problem areas commonly found in addiction patients (McLellan et al., 1980). The ASI is not and was never intended to be a placement tool, but rather an instrument to measure severity of illness. The severity profile in the ASI is based on the numbers and types of problems the client has experienced in the last 30 days and in the past year.

The Recovery Attitude and Treatment Evaluator (RAATE) is an instrument for determining severity using multidimensional assessment focusing on five dimensions. The biopsychosocial severity profile produced is the result of clinical judgment based on history data and examination of current functioning (Mee-Lee, 1988). Since it measures severity at a cross-sectional point in time, the severity of illness will show change, sometimes within a day or two.

Gastfriend and associates (1994) have reviewed both the ASI and the RAATE in detail. They provided a comparative analysis that is oriented toward managed care and patient placement criteria.

The Minnesota criteria use a Level of Chemical Involvement Scale that puts clients in one of four levels of severity, ranging from Level 0, which describes clients who present for assessment but for whom chemical use is not currently a problem; up to Level 3, which represents the most severe level of chemical involvement. Placement is guided by the Level of Chemical Involvement in conjunction with a variety of behavioral and social factors such as legal or family problems.

The ASAM patient placement criteria focus on six dimensions to define biopsychosocial severity:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications

3. Emotional/behavioral conditions and complications
4. Treatment acceptance/resistance
5. Relapse potential
6. Recovery environment.

Criteria listed under these six dimensions help guide placement of the patient in one of four levels of care described below. This is the first step in matching patients to treatment.

Biopsychosocial Treatment and Matching

To achieve cost-conscious addiction treatment, the next step, after a unified model of addiction and assessment of severity is agreed upon, is to define the biopsychosocial treatment to match the patient's clinical severity. Biopsychosocial treatment of alcohol and other drug disorders depends on the availability of a comprehensive system of levels of care, a range of treatment modalities within those levels, and a continuum of care (Miller et al., 1984).

Patient placement criteria are a necessary but not sufficient determinant of patient-treatment matching. Once a patient is placed in an appropriate level of care, selection of the specific assessment-based modalities, eventually guided by empirically based practice guidelines, completes the individualized treatment match.

Levels of Care

Minnesota developed placement criteria for its continuum of care that ranges from primary residential treatment in a hospital or nonhospital setting to outpatient treatment, extended care, and halfway house settings. Patients are placed in a particular level of care as determined by their level of

chemical involvement and other criteria.

The report of the Institute of Medicine (IOM) defines four levels of care that constitute the continuum of care (Institute of Medicine, 1990):

1. Inpatient
2. Residential
3. Intermediate
4. Outpatient.

The ASAM patient placement criteria also describe four levels of care but they are more descriptive of the *intensity* of service provided.

While the ASAM criteria provide specific guidelines on the kinds of setting, services, staff, assessments, and documentation that pertain to each level of care, they contain no mandate on the location necessary for each level, for example, that Level III must be in a freestanding residential facility. Level III might well be provided in a hospital in conjunction with a Level IV program, allowing efficient flexible movement of patients through the continuum.

Modalities of Treatment

The range of treatment modalities depends on the variety of theoretical models integrated into the biopsychosocial model. The IOM report describes modalities as "the specific activities that are used to relieve symptoms or to induce behavior change." It also notes that "the content of treatment is usually referred to as the technique, method, procedure, or modality" (Institute of Medicine, 1990).

Biomedical modalities focus on improved detoxification regimens, anticraving medication, antagonist medication, methadone treatment, and psychopharmacological approaches.

Psychological treatment modalities range from addiction counseling to psychodynamic and cognitive-behavioral treatment modalities, including insight-oriented psychotherapy, aversion therapy, and behavioral self-control training.

Sociocultural treatment modalities include the community reinforcement approach, family therapy, therapeutic communities, vocational rehabilitation, various motivational techniques, culturally specific interventions, and contingency management. In fact, many modalities include more than one dimension such as social skills training, relapse prevention techniques, self- and mutual-help programs, 12-step programs, Rational Recovery, and chemical aversion therapy.

In the case of program-driven treatment, all or most patients receive the same service components, irrespective of individual needs. Using biopsychosocial assessment, the choice of treatment is more clinically driven. Thus, the use of PPC can make it possible to relate clinical determination of biopsychosocial clinical severity to intensities of service. Specific problems can be identified that require specific types of attention. Treatment planning can then be conducted, responding to the identified problems by selecting from a range of biopsychosocial treatment modalities. The appropriate intensity of services can be selected, with the result that the patient can be placed in the least intensive, safe level of care and specifically treated with strategies selected from a range of biopsychosocial treatment modalities.

The patient's response to treatment and treatment outcomes can then be monitored by assessing the changing biopsychosocial clinical severity for improvement or deterioration in any or all of the dimensions, especially the high-severity dimensions. Individualized treatment is the ongoing repetition of this cycle as the regularly assessed clinical severity is matched with the appropriate level of care and range of treatment modalities.

Asam Levels of Care

- **Level I: Outpatient treatment**
- **Level II: Intensive outpatient/partial hospitalization**
- **Level III: Medically monitored intensive inpatient treatment**

- **Level IV: Medically managed intensive inpatient treatment (Hoffman et al., 1991)**

Implications

The "retooling" of the addiction treatment system necessary to promote individualized treatment requires a shift that has broad implications for the AOD abuse treatment field, public- and private-sector programs, payment systems, clinicians, and patients. If this shift occurs successfully:

- The AOD treatment field will develop one uniform set of clinically based placement criteria.
- Public and private-sector programs will develop a single system of comprehensive care that can be matched with the placement criteria.
- Programs will expand their continuums of care to provide multiple levels of care with flexible lengths of stay.
- Payers will reimburse and fund all levels of care to allow patients to be placed in and move around among the most efficient and effective settings.
- Clinicians will become more skilled at comprehensive assessment and have a broader knowledge of placement criteria and treatment modalities for better patient-treatment matching.
- Patients will receive care that is not only more cost efficient, but more cost effective.
- As patients receive treatment in the least intensive yet safe setting, they can test recovery skills in situations as close to "real world" conditions as possible, and minimize reentry problems.

Healthcare costs can no longer support inefficient care born out of programs with one level of care and one treatment protocol for all patients regardless of the clinical heterogeneity assessed, or too often, not assessed. Patients who present for treatment are becoming increasingly diverse. Many are polydrug users. Some have dual diagnoses (mental illness and substance abuse). As a group, they are young, with psychological and social impoverishment.

Increasingly, there is a greater gender and ethnic mix. Consequently, staff skills and treatment options must also become more diverse.

Summary

Within the managed care environment, as providers struggle with the pressures of cost containment, accountability, and documentation, it often seems there is little time to focus on the patient. Yet, if we are to protect access to quality care, managed care organizations and the treatment community must work together to make the transition to new cost-conscious systems of care that incorporate careful assessment and individualized treatment. Uniform patient placement criteria can play an important unifying role in this process.

Endnote

1.This chapter, initially written by David Mee-Lee, M.D., and revised for this TIP, describes the rationale and challenge of the transition to more cost-conscious systems of care.

Chapter 3—Critique of Existing Criteria

The use of specific patient placement criteria (PPC) to determine placement of substance-using patients in treatment is a relatively new concept within a continually changing field. Increasing numbers of people with alcohol and other drug (AOD) addictions are accessing treatment through managed care organizations. These organizations attempt to place patients in the least restrictive and least expensive treatment setting that is most likely to produce positive treatment outcomes. In making decisions about the use of AOD services, each managed care organization must have a set of criteria by which to make patient placement decisions. In effect, for every managed care organization in existence, there is a separate set of PPC.

Both public and private treatment systems are increasingly developing and utilizing PPC. Treatment providers are using various sets of PPC to help move patients through their continuums of care.

No single set of existing PPC is uniformly applicable. However, the consensus panel that developed this Treatment Improvement Protocol (TIP) agreed that a comprehensive set of patient placement criteria should address the characteristics listed in Exhibit 3-1.

As a step toward achieving reasonable consensus on uniform patient placement criteria (UPPC), the panel chose to start with the criteria developed by the American Society of Addiction Medicine (ASAM). These criteria address more of the characteristics listed in Exhibit 3-1 than any other criteria. They also represent the most recent set of consensus criteria, as they arose from the National Association of Addiction Treatment Providers (NAATP) criteria and the Cleveland criteria. The panel also examined available PPC from both public and private treatment systems, aiming for recommendations that represented the best within all the criteria sets.

The panel undertook the analysis and discussion of existing patient placement criteria with the hope that others could build on what has already been accomplished by others in the public and private sectors.

Within this context, the ASAM criteria were examined at length. With the strengths and weaknesses of the ASAM PPC clearly identified, treatment systems developing and revising their own PPC may choose to incorporate the strongest elements of the ASAM criteria, adapting them as needed. It was determined that the ASAM criteria form the best existing base on which to add levels of care to develop an interim set of PPC, with the goal of eventually developing a completely revised set of criteria.

While the proliferation of private PPC prohibits discussing each set individually in this TIP, the panel offers a summary of the common characteristics. Review of these criteria sets played an important role in identifying the next steps in UPPC development. After examining the PPC currently in use, the panel identified several levels of care, services, and modalities for which additional criteria should be developed.

ASAM Criteria Analysis

It is not just the wider recognition of the ASAM criteria that made them the focus of careful analysis. The ASAM criteria constitute the most comprehensive document to lay out a framework and specific descriptors for matching the patient's multidimensional clinical severity to a placement in the most appropriate level of care. They embody important concepts that promote individualized, cost-effective treatment. These concepts include the need for a broad continuum of care and for comprehensive assessment and treatment to address patients' physical, psychological, and social needs. The panel's analysis of the ASAM PPC is neither a criticism nor a defense of these criteria. Rather, the analysis is intended as instructional and of potential benefit in the development of UPPC.

Exhibit 3-1 Characteristics of a Comprehensive Set of Patient Placement Criteria

Client Characteristics	**Service Characteristics** Intensity of services
Age, gender, ethnic, and cultural background	Intensity of environmental support
Severity and course of illness, experiences with previous treatment	Availability of medical services
Relapse potential	Variety of professional disciplines involved
Need for medical or addiction treatment or pharmacological, psychiatric, familial and social, employment, or legal services	Availability of services specific to cultural background, age, sex, or disabilities
Attitude toward entering and continuing treatment	Program elements
Effects of environmental and social influences, such as living situation, family support, and susceptibility to abuse or neglect.	Discharge planning
	Patient-to-staff ratio.

Various critiques and some public-sector adaptations were used in the analysis of the ASAM PPC strengths and weaknesses. The critique described in this chapter represents what was learned from the analysis of the ASAM and other criteria and addresses issues related to the ongoing development of UPPC.

Review of Existing Analyses

Three analyses of the ASAM criteria were reviewed by the consensus panel. While other authors have written critiques of the ASAM criteria, these three address most of the positive aspects and deficiencies mentioned in other reviews of ASAM's work. The analyses are:

- An April 1994 memorandum by David R. Gastfriend, M.D., of the National Center for Addictions Treatment Criteria at Harvard Medical School, entitled "Anticipated Problems Facing ASAM Patient Placement Criteria," which arose out of a meeting of the ASAM Criteria Committee
- An analysis of the ASAM PPC by Richard A. Rawson, Ph.D., and Walter Ling, M.D., of the Matrix Institute on Addictions in California, 1994
- An April 1994 analysis of ASAM's PPC by Henry Harbin, M.D.; Clarissa Marques, Ph.D.; Jonathan Book, M.D.; Chip Silverman, Ph. D.; and Suzanne Lizanich-Aro, R.N., M.P.H., for Green Spring Health Services Inc., entitled "On the Use of ASAM's and Green Spring's Alcohol and Drug Detoxification and Rehabilitation Criteria for Utilization Review." (This prepublication paper, while not fully discussed by all in the workgroup, was included as a reference since it raised many of the same points as the other two analyses. It is a systematic comparison of the ASAM and Green Spring sets of criteria.)

Overview of the ASAM Criteria

The ASAM criteria establish four levels of care:

1. Level I: *Outpatient Treatment*
Nonresidential service or office visits, totaling fewer than 9 hours a week, in which directed treatment and recovery services are provided that help the patient cope with life tasks without the nonmedical use of psychoactive substances.
2. Level II: *Intensive Outpatient/Partial Hospitalization*
A programmatic therapeutic milieu consisting of regularly scheduled sessions for a minimum of 9 hours a week in a structured program, which provides patients with the opportunity to remain in their own environment.
3. Level III: *Medically Monitored Intensive Inpatient* Inpatient treatment in a planned regimen of 24-hour observation, monitoring, and treatment; utilizes a multidisciplinary staff for patients whose biomedical, emotional, and/or behavioral problems are severe enough to require inpatient services.
4. Level IV: *Medically Managed Intensive Inpatient*
Primary medical and nursing services and the full resources of a general hospital available on a 24-hour basis with a multidisciplinary staff to provide support services for both alcohol and other drug treatment and coexisting acute biomedical, emotional, and behavioral conditions that need to be addressed.

The purpose of the criteria is to use a comprehensive biopsychosocial assessment to make objective, clinically based patient placement decisions regarding the most appropriate level of care. These assessments and assignments to levels of care are based on six patient problem areas that are referred to as *dimensions*:

Dimension 1: Acute intoxication and/or withdrawal potential
Dimension 2: Biomedical conditions and complications
Dimension 3: Emotional/behavioral conditions and complications
Dimension 4: Treatment acceptance/resistance
Dimension 5: Relapse potential
Dimension 6: Recovery environment.

Important Aspects of ASAM Criteria

The ASAM criteria were designed to provide guidelines for placing patients with specific combinations of problems in appropriate levels of safe and cost-efficient care. It should be noted that they are not treatment/service matching criteria. Matching is based on the identification of patient needs for a wide range of services. PPC are not meant to address every individual need.

Several important aspects of the ASAM criteria that are instructional for the future development of UPPC are summarized below. Many of these points also apply to several sets of public-sector PPC.

Developed by Consensus

The ASAM criteria were developed through the consensus of a range of clinicians representing counselors, social workers, psychologists, and physicians. By creating and rewriting drafts for consensus approval, ASAM produced a document that has undergone extensive field review.

However, there were several shortcomings in the consensus process for the ASAM criteria. The most active contributors had similar clinical backgrounds and the volunteer consensus was achieved by groups familiar with one another, so that the treatment field was only partially represented. Therefore, the ASAM PPC have gaps that must be identified and filled by other groups in the AOD treatment field.

Visibility

The ASAM criteria, with over 4,000 copies in circulation, have received high visibility in the

treatment field. But a negative consequence of being sponsored by a voluntary professional organization is the lack of financial support to widely distribute information. There is room for broader distribution of the criteria in the treatment, policy, and research areas. For instance, nurses and psychologists, who were underrepresented in the development of the criteria, will use PPC. However, they have not been as aware of the ASAM PPC as others in the field.

Continuum of Care

A particular strength of the ASAM criteria is that they address adult and adolescent treatment separately and encourage a broader continuum of care than the traditional focus on inpatient and

aftercare only. However, some omissions limit the usefulness of the ASAM-defined continuum of care for substantial sectors of the treatment field, particularly the public sector.

- Several levels of care—primarily found in the public sector—are not clearly included (e.g., long-term residential care and social model detoxification centers).
- There are at least two well-recognized treatment modalities that have taken on the characteristics of levels of care but are not yet included in the criteria. These include opioid substitution therapy (such as methadone maintenance) and therapeutic communities.
- The lack of clear identification of and distinction between "partial hospitalization" and "intensive outpatient" care is a problem, particularly for the managed care community.
- There appears to be a prejudice toward higher intensity inpatient levels of care, with less emphasis on outpatient care such as intensive outpatient detoxification or other outpatient treatments.
- Insufficient emphasis is placed on special populations of great concern to the public treatment system (such as injection drug users and their sexual partners, pregnant women, and the chronically underserved, including ethnic minorities and the homeless).
- The criteria for opiate and cocaine use are not as well articulated as the criteria for alcohol use.
- Women's psychosocial issues are largely unaddressed, which can affect how criteria for levels of care are determined.

Common Language of Categorized Levels of Care

A strength of ASAM's criteria is that they characterize levels of care and patients in some detail. This common language of levels of care, multidimensional assessment of severity, and specific placements of patients in a level of care give the treatment field systematic ways to describe the treatment continuum and identify where patients belong in the continuum.

However, all current PPC, including the ASAM criteria, use categorized levels of care in which a specified set of services and modalities are "bundled" into one level of care. For example, a Level IV treatment program must offer acute hospital resources; physician management; life support services; psychoeducation programming; individual, group, and family counseling; and continued care planning. Any one patient may not need all of the services, but the categorized, bundled level of care discourages full flexibility to meet the individualized needs of patients.

Categorized or bundled levels of care in the ASAM criteria are limited by their rigidity and are beginning to give way to "unbundled" sets of services, settings, and environmental structures.

Cost Benefit

A strength of the ASAM criteria is the potential for cost savings. A major difference in cost is spanned in distinguishing between Level III and Level IV treatment (medically managed vs. medically monitored; acute care vs. subacute care). Previously, Level III (short-term, medically monitored, residential treatment) was frequently provided in hospital settings at acute-care rates. The codification of a continuum of care, although limited to four levels of care with the gaps mentioned above, provides PPC that can help move the treatment field toward more comprehensive and cost-effective continuums of care.

Reliable Measures Needed

While a strength of the ASAM criteria is that they incorporate a broad and comprehensive multidimensional assessment of the patient to determine the appropriate level of care, a related weakness is that there are currently no reliable and widely accepted ways to measure these dimensions. A great challenge in the development of any PPC is accurately determining the degree of specificity or generality that will most clearly, objectively, and validly guide appropriate clinical decisionmaking.

User Friendliness and Degree of Specificity

The ASAM PPC address a wide range of clinical presentations by using the multidimensional assessment and systems approach to describe a variety of clinical severities. The criteria simulate expert human thinking that looks at patients as individuals with specific needs, often spanning several assessment dimensions. However, this approach can be cumbersome because it is a written method of complex human decisionmaking. This makes it difficult to standardize and makes rules difficult to learn, memorize, and use. The ASAM PPC are perceived by some as too complicated for use as a utilization management tool and best used as a treatment planning tool.

Some have argued that the six dimensions for assessment lack clarity and should be more specific about the conditions in the various levels of care. The lack of clarity allows for significant variability in interpretation. On the other hand, too much specificity leads to rigid, rule-bound decisionmaking and too detailed and cumbersome a document. There is no substitute for clinical judgment by a credentialed professional in comprehensive assessment and placement decisions.

Future versions of PPC would benefit from greater clarity of the criteria, explanatory detail, examples, and easily accessible footnotes and appendices. Objective tools must be developed to give clinicians some direction for the systematic use of PPC.

A current effort to address this problem is a checklist version of the ASAM PPC known as the Level of Care Index (LOCI) that is commercially available (see Appendix B). It condenses paragraphs of prose from the ASAM PPC to a few words, and greatly facilitates use of the criteria. This model of condensing complicated prose into a more usable format is a good one. However, a risk inherent in use of such tools, especially without adequate training, is that it may lead to superficial assessments without sufficient clinical analysis.

Treatment planning software that incorporates the ASAM six dimensions is also commercially available (see Appendix B). The software allows problem statements in treatment plans to be organized under the six dimensions. The use of computers to rapidly analyze, order, and focus assessment data to facilitate clinical decisionmaking about patient placement and treatment planning is relatively in its infancy. Such developments would help address the need for improved specificity and user friendliness.

Continuity of Treatment

The ASAM PPC offer a framework for continuity of treatment, including admission and continued stay and discharge criteria. These phases of treatment are subject to guidelines for utilization review and quality improvement that require ongoing assessment of patient performance and treatment response. The length of stay in any one level of care depends on the

clinical severity of illness and the patient's response to treatment. Treatment is seen not as the completion of a level of care in a fixed length of stay, but as having flexible continuity throughout the continuum of care. However, the concepts of admission and discharge do not allow for the tapered intensity of treatment that patients might need. For example, when a patient moves from 10 to 9 hours of treatment weekly, the guidelines of the ASAM PPC would automatically discharge the patient from Level II (Intensive Outpatient/Partial Hospitalization Treatment) to Level I (Outpatient Treatment).

Copyright and Nonproprietary Issues

Although the ASAM criteria are copyrighted, ASAM has taken a consensus-building approach and has given permission to use the ASAM patient placement criteria as a base from which to fashion other criteria. Permission can be requested by contacting James F. Callahan, D.P.A., Executive Vice President, American Society of Addiction Medicine, 4601 North Park Ave. Suite 101, Chevy Chase, MD 20815. Telephone: (301) 656-3920.

Additionally, ASAM has expressed willingness to give up its authorship and copyright to a more multidisciplinary body, provided that the new UPPC embody the essential elements of the ASAM UPPC.

Conclusions Regarding ASAM Criteria

The ASAM criteria may form a solid base upon which to add criteria for additional levels of care. They may be useful in the development of a uniform set of PPC for the short term as well as a starting point for a reconceptualized set of criteria for the future. Treatment systems developing, revising, or adapting their own PPC may choose to incorporate the strongest components of the ASAM criteria, adapt them as needed, and add components to fit their own situations. However, a proliferation of different criteria sets will result. Thus, individual treatment systems may have PPC to meet their internal needs but this will not achieve the goal of uniform PPC.

Analysis of Public and Private PPC

In addition to the ASAM criteria, the consensus panel reviewed all sets of available public and private PPC. The objective was to identify the set of criteria representing the best effort to date, and provide a solid base upon which to build. As stated earlier, the panel decided that the ASAM criteria best met these requirements.

Exhibit 3-2 Important Aspects of the ASAM Criteria	
Positive Aspects:	**However:**
Developed by consensus	AOD treatment field only partially represented
Widely circulated in the AOD treatment field	Lack of financial support for broad enough distribution
Encourage a broad continuum of care	Some levels of care and treatment modalities not included
Use common language for levels of care	Categorizing levels of care can discourage individualized treatment
Potential for cost savings	Cost savings may not be realized in the "gaps" that exist in the four levels of care
Broad, multidimensional assessment	Currently no reliable way to measure these dimensions
Systems approach simulates expert human thinking	Can be difficult to use
Provide framework for admission, continued stay, and discharge.	May not adequately allow for tapering intensity of treatment.

However, several sets of PPC, both public and private, were impressive in numerous ways and represent improvements to the ASAM PPC and models for future PPC development. A full review, analysis, and discussion of all documents would require work beyond the scope of the consensus panel. Other PPC that were not in the possession of the panel will need review as well. Appendix B includes information about obtaining copies of most of the criteria sets reviewed by the panel.

Public Criteria

Several States have adopted variations of the ASAM criteria to fit their systems. PPC from public treatment systems that were modeled on the ASAM criteria clearly share many of the fundamental strengths and weaknesses of those criteria. However, many States have made significant improvements in the ASAM criteria to make them more appropriate to their systems and easier to use.

Iowa

The developers of the Iowa PPC adapted the ASAM model and developed PPC for other levels of care. A significant contribution of the Iowa criteria is that they include PPC for some levels of care that are missing in many public treatment systems such as halfway houses and longer term residential treatment. The Iowa criteria also provide an excellent glossary. The panel was impressed by both efforts but questioned the description of long-term residential PPC. Two distinct levels of care are described: primary residential treatment (50 hours/week of rehabilitation sessions) and extended residential treatment (30 hours/week of rehabilitation followed by other rehabilitation and community services). The panel workgroup felt the PPC should more clearly define the distinctions between the two levels of care.

Illinois

Illinois is creating a short draft addendum to the ASAM PPC, which was not available to the consensus panel. The goal is to make the ASAM criteria more compatible with publicly funded systems. This goal should be a consideration in any adaptation of ASAM criteria.

Massachusetts

Massachusetts has made a significant contribution by creating a statewide consensus panel to recommend changes to ASAM criteria that reflect the State's unique characteristics. It produced PPC for Level I

(outpatient), Level III (detoxification), youth residential, and methadone treatment. It is worth noting that the ASAM Level IV criteria were used for the foundation of their Level III, with language adapted to better reflect the clients treated in the public system. Each amendment the State made to the ASAM text was footnoted, a procedure worth duplicating by others.

A large managed care company has begun to manage the bulk of the Massachusetts Medicaid population. Using the Massachusetts PPC as a conceptual base for decisionmaking, the company has redirected clients from Level IV hospitals to Level III facilities. When this transition began, 50 percent of detoxification episodes were in Level IV hospital programs. In less than 1 year, this rate has been reduced to less than 10 percent.

Washington

Recent State healthcare reform, which will replace mandated chemical dependency healthcare with case-managed chemical dependency treatment services, has stimulated acceptance of the ASAM criteria as the tool for case management. Efforts are now under way to incorporate

specific reference to the ASAM criteria into healthcare reform efforts. Training in the use of the ASAM criteria is ongoing.

Minnesota

The Minnesota PPC preceded the ASAM criteria and are particularly useful as a resource for future PPC. They are more compact and standardized than the ASAM criteria, making them more likely to be applied consistently, but also making them more arbitrary and rigid. Perhaps the greatest usefulness of the effort to establish criteria in Minnesota is not the criteria themselves, but the lessons learned in the 8 years of experience implementing them.

Private Criteria

Private behavioral health managed care companies are actively taking steps to examine the PPC that they collectively use. They recently formed a Managed Care Coalition on Substance Use Disorders, a subcommittee of the Coalition for National Clinical Criteria, with the goal of creating a unified voice for their services in the healthcare reform environment. In this process, they have shared information that was previously withheld as proprietary and are demonstrating a willingness to explore and support the development of standardized PPC.

It is important to note that, for the most part, the criteria are specifically designed as utilization management tools, indicating the *minimum* requirements for entering a level of care. This approach substantially differs from that of the ASAM PPC, which were not designed as a utilization management tool, but to provide the conceptual framework and specifics for patient placement.

A Comparison of Private Criteria and the ASAM PPC

The panel workgroup reviewed several sets of criteria from private managed care providers and compared them with the ASAM PPC. Generally, the workgroup found that the criteria devised by managed care entities consistently differ from the ASAM PPC. They are more concise and substantially more restrictive regarding access to the intensive levels of care. In addition, they emphasize the distinction between the use of partial hospitalization and intensive outpatient treatment (Level II). They tend to focus on psychiatric factors and often demonstrate less awareness of the unique aspects of substance abuse treatment as compared with other components of their services.

Core Elements of Managed Care PPC

The panel workgroup found many similarities among the sets of criteria developed by managed care companies. They have, in some cases, divided the services designated as Level II services by ASAM into two distinct components: partial hospitalization and intensive outpatient care.

The common core elements of the partial hospitalization level of care include:

- A focus on AOD dependence rather than AOD abuse

- A minimum of 4 to 6 hours per day of services
- Twelve to 20 hours per week of treatment services (clients may or may not receive services every day but get a minimum of 4 to 6 hours of service on treatment days.)
- Provision of nursing staff and appropriate medical services
- Regular access to psychiatric services.

The common core elements of the intensive outpatient level of care include:

- A focus on AOD abuse rather than AOD dependence
- A minimum of 9 hours of treatment services per week
- No requirement for nursing staff, medical services, or frequent psychiatric services.

These systems have been leaders in the development of ambulatory outpatient detoxification services.

The managed care PPC appear to be highly restrictive in terms of permitting any 24-hour level of AOD care. Examples included requiring severe psychiatric problems as a condition of admission or not allowing a readmission to residential treatment if such treatment has been delivered in the last 5 years.

Another TIP in this series, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, documents the clinical viability and utility of the intensive outpatient level of care.

"Restorative Potential"

Some managed care providers use "restorative potential" (the ability and willingness of a client to benefit from treatment) as a factor in deciding level of care. The concept of restorative potential has been used to limit or deny services to clients who are perceived as using treatment services excessively or who have a bad track record of complying with treatment. Some providers use it to assign the client to a less intensive level of care. For the client with a history of relapse problems, a more appropriate clinical approach would be a careful assessment and identification of the barriers to recovery. However, addressing recovery barriers does not absolve patients from responsibility. The appropriate use of restorative potential involves assessment of both external barriers to recovery and the patient's investment in the process. Failure to address specific recovery barriers and match the client to appropriate services and settings only increases the human and financial cost to the client and society.

Interim Recommendations For PPC

For public and private institutions preparing to adopt, write, or amend PPC for their clients with AOD addictions, the consensus panel recommends interim steps until a new set of criteria can be developed. The interim criteria must effectively address the accepted shortcomings of the ASAM PPC and incorporate the best components and aspects of other excellent PPC now available. The panel recommends that:

- The ASAM PPC be used as a baseline document upon which to build
- The Massachusetts and Iowa PPC be used as a basis for adding methadone treatment, adolescent residential treatment, and halfway houses to the ASAM criteria
- Others develop PPC for "missing" settings, services, and modalities consistent with the ASAM style
- Prevention/early intervention be added as a fifth level of care.

A discussion of each of these recommendations is presented in the following sections.

The Coalition for National Clinical Criteria has, in the course of three meetings, discussed the need for modifications to the ASAM criteria. These modifications address many of the same gaps in service identified by the consensus panel workgroup. On September 9, 1994, the coalition voted to proceed with the development of a supplement to the ASAM criteria that substantially addresses the panel's interim recommendations. ASAM has expressed a willingness to fund the publication of this supplement with a projected publication date of June 1995.

ASAM PPC as a Base Document

The ASAM criteria were chosen by the panel as a baseline document for many reasons. Although incomplete and flawed in some respects, they provide the most thorough and systematic model to date for assessing key dimensions of patient need. They systematically link these dimensions with a specified level of care.

- They have been through a more comprehensive formal and informal review process than any other PPC, are the most widely known, have generated the most discussion, and provide the most comprehensive structure (clearly defined levels of care, six dimensions, and admission and continued stay and discharge criteria for both adults and adolescents).
- Although conceptually different criteria of other groups and States have been examined, they have not been found to significantly improve on the ASAM PPC.
- They are the *de facto* base on which many other criteria have been built.
- They have drawn the most interest by researchers.
- The ASAM six-dimensional assessment framework—with clearly defined levels of care and admission, continuing care, and discharge criteria—is a clinically comprehensive model and would most easily be accepted as the best single base document upon which to build across the treatment field.

Massachusetts and Iowa PPC

Additional PPC should be added to the ASAM base document to include levels of care that are widely recognized as missing from the ASAM criteria. Several have been identified that are well developed and consistent with the ASAM PPC methodology.

Systems preparing to incorporate, develop, or revise existing PPC would benefit from studying the following PPC and incorporating portions of them—as is or amended—into their PPC.

These include:

- The Massachusetts PPC for methadone treatment and adolescent residential treatment. These criteria follow ASAM methodology and have already been adopted as an addendum by ASAM. Additionally, their Level III adaptation is probably a better fit for public detoxification programs than the ASAM Level IV.
- Iowa PPC for residential treatment programs. However, these PPC attempt to combine two distinct levels of care—primary residential and extended residential—into a single set of criteria. These two levels of care are actually quite distinct, designed for different purposes, and serve different clinical populations. This model is not yet as clear as it could be. With relatively minor adjustments, these criteria could serve as an excellent base for short-term, more clinically intensive residential treatment and longer term residential programs. It may be wise to separate short-term care from extended care in developing UPPC.

Addressing Gaps in ASAM Levels of Care

In reconceptualizing the level of care model in this interim period, the panel suggests that the four-level system be maintained as an umbrella system under which other more specific criteria and "sublevels" of criteria can be incorporated. The panel suggests the following structure for temporarily organizing multiple levels of care.

Under Level I, Outpatient Treatment, there are currently a wide range of outpatient treatment models used in the AOD treatment field. The ASAM PPC now include outpatient care and methadone treatment, but there is nothing specifically designed for the many other low-intensity treatment models.

Under Level II, Intensive Outpatient Treatment/Partial Hospitalization, there are two distinct types of services in the treatment field, Intensive Outpatient and Partial Hospitalization. While there are no ASAM-type criteria that separate these "sublevels," managed care organizations do have basic admission criteria for them. A review of some of their criteria suggests certain core elements that generally define these two services (described earlier in this chapter). These core elements should be developed into PPC of the ASAM type. In addition, a TIP in this series, entitled *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, describes one approach and a range of services and core components at this level of care.

Under Level III, Medically Monitored Intensive Inpatient Treatment, there are several types of 24-hour residential treatment programs, some of which provide medically monitored detoxification services. These include halfway houses, social detoxification centers, therapeutic communities, extended (low-intensity) residential, and short-term intensive rehabilitation treatment. The ASAM PCC are now available for halfway houses and, with some amendment, short- and long-term residential treatment. They are not currently available for therapeutic communities or social detoxification; with the exception of halfway houses, no criteria seem to adequately characterize 24-hour residential programs.

Level IV, Medically Managed Treatment, requires no division into sublevels. However, as noted earlier, the criteria overstate the need for the hospital level of care in today's treatment environment. Programs are finding they can perform detoxification in various nonhospital inpatient and outpatient settings. Further work needs to be done to update these criteria and determine the most appropriate clients to be detoxified in less intensive inpatient and outpatient

settings without substantial physician involvement. A TIP under development in this series, *Detoxification from Alcohol and Other Drugs*, provides extensive detoxification guidelines for use in a variety of settings, including outpatient settings.

Some have argued that the level-of-care umbrella might be more useful if Level III were redefined as 24-hour Residential Treatment (that may or may not be medically monitored). Under this umbrella, all of the sublevels now under Level III would remain except Level III, Detoxification, which would be recategorized under a new Level IV (24-hour Residential Detoxification). The panel is not recommending this amendment, but the idea may be useful to consider during this interim period.

Prevention/Early Intervention Level

A necessary additional level of care in future PPC development is Prevention/Early Intervention. Many health maintenance organizations (HMOs) and public treatment systems already include prevention as a major part of their budgets, and the prevention system is a key component of certain treatment systems. For instance, HMOs and other capitated/fixed-payment systems of care have financial and clinical incentives to reach out to their served population. They offer preventive education (primary prevention) and identify high-risk individuals, to whom they provide education and intervention (tertiary prevention). They may also provide interventions to minimize the risk of relapse or more expensive treatment at a later time.

In the future, one can expect to see an increasing number of systems with this level of care as well as more attention focused on prevention. Prevention efforts could include training for doctors and other medical personnel, educators, criminal justice workers, and social service providers in the methods for brief but effective interventions that consist of one or a few meetings.

A necessary additional level of care in future PPC development is Prevention/Early Intervention. Criteria in this area would allow a client to enter the treatment system at a prevention level before an acute episode necessitated treatment at a more intensive level.

The prevention level of care could include structured relapse prevention services in Level I (outpatient care). For example, in the current system, access to AOD benefits usually requires a recent episode of AOD abuse. But patients experiencing stress and in danger of relapse may require immediate addiction treatment expertise. When funders exclude access to AOD benefits in these situations, the likelihood of relapse increases, which leads to the costly need for acute care. Criteria in this area would allow a client to enter the treatment system at a prevention level before an acute episode necessitated treatment at a more intensive level.

"Unbundling"

The CSAT consensus panel members were unanimous in their belief that future PPC need to become far less categorized, allowing treatment providers and purchasers to choose the most appropriate combination of setting, treatment, and intensity of services to meet the client's individual needs.

To address the rigidity of the current system, many managed care companies and public treatment systems are now suggesting that treatment modality and intensity be "unbundled" from the treatment setting. Unbundling is a practice that allows any type of clinical service (such as psychiatric consultation) to be delivered in any setting (such as a therapeutic community). With unbundling, the type and intensity of treatment are based on client need and not on limitations imposed by the "category" of care they are in, or whether they are sleeping in a halfway house or hospital. Indeed, a new type of care is emerging that combines partial hospitalization with room and board. The unbundling concept is designed to maximize individualized care and encourage the delivery of necessary treatment in any clinically feasible setting.

Examples of Unbundled Care

There is a pilot program under way in Montana with Blue Cross and Blue Shield that offers reimbursement based on a continuum of service. Blue Cross and Blue Shield offers a $500 benefit for a segment of treatment but does not specify the setting. The treatment can take place in a hotel, halfway house, or during a short-term retreat. Other examples of unbundling include providers who have capitated contacts with managed care companies or other insurers. They have the option and are financially motivated to arrange for a modality of care wherever it is clinically appropriate. This maximizes positive outcomes in the most cost-efficient manner.

The following are hypothetical examples of an unbundled system delivering unique treatment plans that a rigid, categorized system may not easily deliver.

The possibility of an unbundled system delivering a range of levels of care with limited resources is shown in the cases of Mrs. R. and Mr. Q. (see boxes on this page and next). Their options in a system with little flexibility are described first, followed by possible options in an unbundled system.

Hypothetical Example: Mrs. R

Mrs. R is assessed as needing the structure of a scheduled outpatient program (one individual and one group counseling session per week) that allows her to address her rapidly growing cocaine dependency while actively engaging in a daytime job-training program. However, her assessment indicates that she also needs access to a combination of services and settings that may not be accessible in a rigid system of care. Her assessment indicates that:

- She needs a thorough psychiatric evaluation and perhaps medication management that her AOD abuse treatment program does not offer.

- She has two children, no funds to pay a babysitter, and no responsible friend or family member to watch the children.
- She needs transportation, or she will not be able to get to the clinic.
- She lives next to a crack house and acknowledges that she has little chance of maintaining abstinence if she goes home at night. She will not be able to move in with her sister for 3 weeks and needs a place to sleep until then.

In the current categorized treatment system, Mrs. R might be offered the same basic treatment as every other patient, usually one individual and one group counseling session each week. The program may try to refer her to the mental health center across town to get on the waiting list for a psychiatric evaluation, encourage her to try to find someone to provide childcare and transportation, and make her aware of the AA meetings that are held every night. Even the best clinician would have few options to meet this woman's needs.

However, in an unbundled system that tailors the treatment plan and receives payment for its components, the clinician would be able to design a truly individualized treatment plan for Mrs. R. She would receive psychiatric counseling from a psychiatric service that offers a variety of treatment settings. She would be placed in a moderately priced hotel (with which the clinic has developed a business relationship) until she could move. Transportation would be offered by a vendor. A babysitter would be available three nights a week at the clinic and paid for by a separate fund. Mrs. R would have counseling sessions at night to allow her to continue her essential job training.

Unbundling may alleviate some of the problems of providing a continuum of services in rural areas. Using a program that has a recovery house with medical monitoring capabilities and an outpatient program with a case management focus as an example, much of the continuum of care can be covered with two resources.

Hypothetical Example: Mr. Q

Mr. Q. is single. He is stably but marginally employed and lives with friends near a rural population center. He has been referred to the court because of a second offense of driving while intoxicated. He has agreed to referral to an outpatient treatment program, but continues to become intoxicated.

He is then referred to an inpatient program and has a new counselor. Reassessment reveals that Mr. Q has a more extensive drinking problem than first known. He also has serious grief and loss issues and a history of sexual victimization. To meet his many newly identified clinical needs, Mr. Q is referred to an extended care residential program. This requires a move to another facility (perhaps in another town). Once again, he must change counselors.

At the successful completion of his extended care program, Mr. Q is referred to a halfway house to improve his independent living skills and enroll in job training. He is admitted to a different program and assigned to a new counselor.

In an unbundled continuum, Mr. Q would initially participate in assessment and outpatient treatment. When that proves insufficient to meet his needs, he would move into the residential facility, keeping the same counselor. As additional problems become apparent, his treatment plan would change, altering the mix and intensity of services. Although he may receive some services from different team members, his initial counselor would always be available. In some systems, this counselor would act as his case manager; in others, Mr. Q would have an independent case manager assigned to him. As he resolves some of his issues, his treatment plan would continue to change.

Ultimately, the services would be focused on independent living skills. Mr. Q. would not have to move from one facility to another, nor would he have to fail at one level of care to obtain the next.

Treatment Campuses

An example of a setting in which unbundled treatment might be easily delivered is a large treatment campus that has a variety of services available at one site. This campus might include a hospital-based addiction program with a methadone clinic, a day and evening structured outpatient program, a psychiatrist, childcare and transportation services, and a low-cost residential setting. Clients would easily receive an individualized treatment plan that would specify the appropriate frequency, intensity, and type of treatment services. Clients would move from one treatment modality and setting to another, based on assessment of their immediate needs rather than on some categorized, preset time schedule.

Another example is a halfway house that might minimally require a 24-hour setting with possibly 5 hours of group counseling per week. However, a particular halfway house might have a licensed practical nurse on staff 20 hours a week to provide medical services and a psychiatrist or other mental health clinician who visits the program once a week. Additionally, this program might offer transportation to employment and other treatment services. The purchaser might pay $50 per day for the minimum core halfway house service and a specified additional amount for the nursing, psychiatric, and transportation services.

Additional Services

Other examples of services and modalities that might be provided in an unbundled system to supplement minimum core services might include child care, onsite or community-based case management, overnight accommodations or sleeping quarters with or without supervision, psychiatric evaluation and medication management, ambulatory detoxification capability, nursing coverage, mental health professional staff coverage, specialized ethnic and cultural capabilities, and high-intensity clinical programming. A treatment provider would create a menu of services offered with the unit cost of each. This cost would either be billed to the appropriate agency or agencies or monitored in a *capitated* arrangement (as described below).

If patient placement criteria are designed to address both categorized and unbundled treatment, they will contribute to the most clinically appropriate and cost-effective care possible.

Paying for Unbundled Treatment

Two methods of payment are most likely for unbundled services.

Incremental charges. There would be a charge for core-level treatment, and each incremental "unit" of treatment or service.

Capitation. The other main option is *capitation*, the establishment of a fixed amount of payment for services for an individual client during a specified period. There is wide variety in the way capitation principles are carried out in different localities. The basic principles used in a capitation method of paying for AOD treatment include:

- Treatment providers receive a fixed amount of payment per patient for a specified period such as a month or a year, sharing in the financial risk if the patient is either under- or overtreated.
- Clinical providers make decisions about treatment or, in some localities, case management programs assume primary decisionmaking responsibility for patients and coordinate all care among multisystems.
- Clinical providers have flexibility for individual management of the patient.
- Effective monitoring of financial impact, access to treatment, and treatment outcome evaluation are included.

It is important that capitation include money for nontreatment services (such as hotel, childcare, and increased case management costs) that are required to support clients who need such services. Future developments in UPPC that include capitation should incorporate financial incentives that encourage quality care, cost effectiveness, and outcomes-based management with strong monitoring of access and quality of treatment.

Challenges of Unbundling

There are several challenges that must be faced in the development of UPPC that unbundle modalities and intensity of care from the setting:

- Fragmentation of services could occur. It is essential to have clear clinical accountability and careful monitoring to ensure that a client's care is carefully coordinated and managed.
- The potential exists for too much complexity in purchasing, contracting, and measuring performance.
- Licensing regulations may pose a problem for unbundling since these regulations by their nature are relatively arbitrary and rigid. Their customary purpose is to define and set clear minimum standards of care. The flexibility that will be necessary in new treatment practices will require new ways of licensing programs.
- Confusion in reimbursement may result during the shift to clinically driven treatment plans from those that are more program driven. Adjustments must be made in reimbursement methods to accommodate flexibility and unbundling of services.

Unbundling of services need not mean that separate services are provided in separate locations. Unbundled treatment may be available as a program offering a menu of services provided in a single location, from which the client and case manager can choose.

Essential to unbundling is the idea that a standard course of treatment can be separated into its component parts, and that those parts can be provided independently of each other in the necessary level of intensity and duration.

While all current criteria—including the ASAM criteria—are categorized systems and thus somewhat limited in their flexibility, it would be a mistake to abandon them and leap immediately to an unbundled system. An essential interim step is to do a better job of defining categorized levels and establishing widely accepted PPC for each level. The refined categorized levels could be seen as stepping stones to unbundling, which will probably occur very gradually and will need thoughtful development.

Recommended Characteristics of Uniform Criteria

While PPC play an important role in matching placements to cost-conscious, effective treatment, current models of PPC need improvement to better match patients to specific modalities, not just to a level of care.

Both payers and providers may accept uniform patient placement criteria, assuming those criteria:

- Accurately describe their levels of care
- Have validity regarding recommended placement level
- Are easy to use in real-time clinical decisionmaking
- Include reliable and objective tools and language
- Encourage positive treatment outcomes in the least restrictive environment.

Without uniformity, there are no common definitions of care, no common language, and no capacity to effectively perform and compare the essential research.

Chapter 4—Building Support for Adopting UPPC

This chapter describes benefits associated with adopting uniform patient placement criteria (UPPC). Special issues to consider in adopting criteria, such as the need to use them flexibly, are addressed. The remainder of the chapter outlines an approach to build support for UPPC among a variety of stakeholder groups at the State level.

Benefits of Adopting UPPC

General Benefits

The primary benefit expected from UPPC is the effect they will have on promoting quality, individualized care. Effectively implemented, UPPC can provide a common framework for matching patients to the levels of care that best address their needs. UPPC have the potential to define, in a common language, a range of services and to facilitate patients' access to them. Once established within a continuum of treatment options, uniform placement standards can help balance the sometimes competing needs for quality and cost effectiveness.

The usefulness of UPPC will be seen in both treatment planning and treatment outcomes evaluation. As with assessment, making placement decisions is an ongoing process, not a one-time event. As patients move through the treatment continuum, decisions about continuing services in the current level in which the client is placed can be reexamined. The outcomes of placement can also be periodically reevaluated. Data obtained from evaluation can then be used to further refine placement decisions, creating a feedback process leading to improved care. An additional result will be a more empirically sound database to use in researching and evaluating treatment content, system gaps, treatment needs of special populations, and geographic distribution of services.

Improving Assessments

The use of UPPC will demand a multidimensional approach to alcohol and other drug (AOD) abuse problems that can address the biopsychosocial nature of addictive disease. UPPC can be used to take into account the various dimensions of patient care and to look at the whole person, identifying for each patient the aspects of illness that are universal and those that are unique to the individual. By structuring the assessment process, UPPC can become a positive force that assists providers in looking at the broad range of treatment options. UPPC guarantee that the assessment addresses the components necessary for successful treatment.

Uniform criteria will require the clinician to focus on observable measures of the severity of illness. Therefore, as a UPPC system is adopted, an anticipated benefit is the impetus it will

provide for the development of more precise screening and assessment instruments, particularly to measure dimensions such as treatment acceptance or resistance, and relapse potential.

Improving Treatment Plans

Two essential elements of UPPC will improve individual treatment plans. The first, a thorough assessment, identifies the patient's strengths and needs and assists the clinician in focusing on the patient's most severe problems and barriers to recovery. The treatment plan, like the assessment, becomes more multidimensional.

The second element, continued stay criteria, addresses why the patient is staying in treatment and what outcomes are expected. Reassessment of patient needs and responses to treatment strategies based on the continued stay criteria guide adjustment of the plan. The individualized treatment plan is thus an evolving document, changing as patient issues are resolved, when outcomes are met, or when treatment strategies do not achieve the desired effect.

Perhaps most important, patients can be more effective partners in their own treatment when the problems being addressed and the desired outcomes are clearly articulated.

Economic Benefits

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Cost-Effective Treatment

Differing costs of treatment are associated with intensity of care. Although less expensive treatment may be desirable, most treatment providers would agree that treatment is not cost effective if it is the wrong treatment. Instead, providing the right treatment at the right intensity *is* inherently cost effective.

Some managed care systems are finding that patients are placed into a particular level of care for addiction treatment services simply because it is available—even if it provides a more intense level of care than necessary. This is neither cost effective nor benefit effective and creates an obvious financial burden. UPPC can promote more efficient contracting for services because there is a check on specific treatment needs, independent of the availability of treatment slots.

Some rural communities with a scarcity of social services find themselves paying for higher cost residential AOD treatment services that are clinically unnecessary. UPPC can clarify when communities are making inappropriate clinical decisions. They can point to the need for more economical choices in resource allocation. In Alaska, for example, most geographic areas have no available community treatment options for nonresidential AOD abuse care. Thus, patients receive only inpatient AOD treatment, when they could benefit equally from outpatient treatment. Having outpatient treatment resources would reduce the overall cost of AOD services. In other parts of the country, historical or funding policy has led to a reliance on inpatient or residential care and an overuse of these costly services for clients who might benefit just as much from lower cost outpatient treatment.

The assumption that "inpatient treatment is best" is being challenged by some outcomes studies. One study of the determinants of treatment placement found that persons with drug-related problems (other than alcohol) who received outpatient treatment had superior outcomes to those who received inpatient treatment. Patients with alcohol problems had similar outcomes in inpatient and outpatient settings (Harrison et al., 1988).

It is important to recognize that the more expensive option of residential treatment is essential for some patients. Offering more than just a stable living environment, residential care provides a therapeutic milieu that may be a critical factor in the successful treatment outcome of some patients. For example, residential care is indicated for many patients who are dually diagnosed or who have functional deterioration in life skills.

Other patients who do not have a clinical need for residential care may have no other option that will provide the intensity of services required. For such patients, placement in residential care will be the most cost-effective treatment: multiple unsuccessful placements will be avoided and healthcare costs associated with continued alcohol and drug use will be reduced. A distinction should be made between hospital-based residential care and community-based residential care, as the cost differential between the two types of care is significant.

An additional clinical and economic benefit of establishing uniform criteria is that UPPC will alter less effective treatment paths that can result from established referral relationships or other nonclinically based referrals.

Implementation of UPPC will provide research opportunities that could furnish a firm scientific basis for treatment choices. UPPC, regularly updated by research findings, may help clinicians identify the clients who will benefit most from each level of care. Placement decisions made in this manner will ensure true cost and benefit effectiveness.

Economic Benefits for Providers

Program personnel must realize that reimbursement changes following the establishment of UPPC may not automatically result in initial direct benefits for the program itself. Rather than resulting immediately, financial payoffs for implementing UPPC are more likely to occur over time, as the continuum of care becomes more cost effective and patient care and outcomes improve.

Implementation of UPPC will provide research opportunities that could furnish a firm scientific basis for treatment choices. UPPC, regularly updated by research findings, may help clinicians identify the clients who will benefit most from each level of care. Placement decisions made in this manner will ensure true cost and benefit effectiveness.

Because many public and private funding sources now use different criteria, treatment providers must use valuable staff time to describe their clients and programs in the language of each funder's criteria. Uniform criteria will allow treatment providers to focus on a single set of criteria that is clinically relevant. Staff time and paper work related to admission, continued stay, and payment arrangements will decrease in proportion to the number of funders relying on the established criteria.

UPPC will help prepare public providers who currently receive their funding from State allotments to receive third-party reimbursements and become more competitive with private programs. Uniform criteria can help many programs and systems prepare for managed care and healthcare reform, because inherent in both is the expectation that programs consistently use established assessment, continued stay, and discharge criteria.

The most clear-cut economic necessity for programs to adopt PPC occurs in States where licensing regulations include such requirements, as in Montana. Massachusetts has included PPC in its contracts for treatment of public-sector clients. Minnesota more directly links funding to the use of PPC. Treatment providers are not reimbursed for treating public-sector clients if those clients were not assessed and placed according to the State's PPC.

Establishing a Common Language

Uniform criteria can bring stability and consistency to the field of AOD treatment, allowing diverse disciplines and organizations to work together. Once implemented, they can provide a common agenda, a common language, and shared expectations about treatment across different groups of multidisciplinary service providers, payers, policymakers, and others. For example, when employee assistance programs (EAPs) and case managers use the same criteria, fewer problems will occur when EAPs refer managed care patients into the treatment system. Good communication in this area assures employers that their employees are getting cost-effective care.

Some commonly used terms have different meanings to different providers. For example, the term "outpatient treatment" can mean: very low intensity early interventions, a structured program meeting several times a week, or daily partial hospitalization. Similarly, "non-hospital-based residential facilities" are, in some areas, sober houses with no professional staff, and in others, highly structured programs with multidisciplinary treatment teams and 24-hour nursing.

In addition to standardizing terminology, UPPC can provide a common basis for understanding the immediate and long-range needs of patients in treatment. They constitute a framework for a variety of groups to use as they engage in a collaborative planning process, especially when more than one system is involved, such as the criminal justice system or human services.

UPPC as an Element in Outcome Evaluation

UPPC, when implemented in conjunction with an outcomes monitoring system, provide several avenues for the improvement of treatment, as they:

- Allow for valid comparisons between programs because common language is used to describe each level of care
- Provide feedback on whether the UPPC are being uniformly applied
- Provide feedback on criteria validity based on the outcomes of clients with certain characteristics who are placed in a specified level of care.

The Center for Substance Abuse Treatment is developing another TIP in this series that will provide detailed information on outcome evaluation, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment.*

Some States are already using patient placement criteria as a starting point to generate outcomes data. This is part of a strategy to demonstrate to legislatures that different levels of care are necessary to address the needs of diverse patients.

UPPC as a Needs Assessment Tool

Use of UPPC can help States identify gaps in the continuum of care, and thus they can be a valuable tool in needs assessment. In rural and other areas where there are limited treatment options, use of UPPC can help document the number of clients who would be referred to a specific option if it were available. Such documentation, used in conjunction with information from the Federal minimum data requirements and waiting lists, can stimulate reallocation and development of needed resources. For example, such data can give added weight to arguments to State legislatures and other funding bodies. In this way, UPPC can influence the development of treatment options in a dynamic, empirically based manner, providing a conceptual framework that will make it possible to identify needs and develop services to meet them.

UPPC and Managed Care

The growth of managed care has already had a significant impact on the U.S. healthcare system by:

- Increasing the emphasis on a continuum of care
- Increasing the importance of assessment
- Creating more focused treatment plans.

There remains a concern that care is being rationed as a result of managed care, to the extent that some persons are denied the services they need. (Rationing is discussed in detail in Chapter 6.) The establishment of UPPC will result in better *communication* between managed care organizations and treatment providers, as both entities will be using the same criteria for placement, continued stay, and discharge decisions. Consumers and purchasers of services can make comparisons between plans, evaluate levels of care, and monitor outcomes. Health plans will then compete on the basis of quality, cost, and outcomes. It is hoped that the establishment of UPPC can bring a greater degree of consistency and stability to the patient placement process.

Benefits of Adopting UPPC

- **Promotion of quality, individualized care**
- **Improved quality of assessments**
- **More multidimensional treament plan**
- **Cost-effective treatment**
- **Eventual economic benefits for providers**
- **Establishment of a common language**
- **Treatment outcomes more readily evaluated**
- **Identification of gaps in the continuum of care**
- **Identification of the elements of effective programs**
- **Opportunity for focused research studies on treatment and cost effectiveness**
- **Establishment of generally accepted practice in the AOD treatment field, which may prevent litigation.**

Resolutions of Disputes About Medical Necessity

Most third-party health insurance plans limit coverage to services and supplies that are "medically necessary." While plans may define the term differently, the intent is to exclude from coverage unnecessary treatment services, equipment, and supplies. Most plans' definition of medically necessary services include, at a minimum, the following elements:

- The service must be ordered by a professional whose license qualifies him or her to diagnose and deliver treatment
- It must be of the proper quantity, frequency, and duration for the condition being treated
- It must not be experimental or investigative.

Failure to satisfy the second element is generally the issue in disputes between AOD treatment providers and third-party payers. The argument often centers on whether the course of treatment is consistent with generally recognized medical standards. The ultimate resolution of many such disputes is in a court of law. The courts take into consideration the contractual terms of the plan or policy, as well as the differing opinions or testimony of medical experts. The outcomes of disputes that are settled prior to litigation are, of course, influenced by how the courts have settled similar cases in the past.

Uniform patient placement criteria, if they are developed according to the consensus-building process outlined in this document, will represent the opinions of AOD abuse treatment providers from many disciplines. The criteria may be viewed by courts as reflecting generally accepted medical practice, especially as the criteria become widespread. In situations in which an insurer or payer has applied its own criteria or standard of medical practice rather than UPPC, the issue in court will in all probability focus on whether the insurer's criteria are significantly different from those of the medical and AOD treatment community.

As UPPC gain acceptance, the standard they provide will help resolve disputes before litigation is necessary (see Chapter 7, Ethical and Legal Issues).

Special Considerations

Development and implementation of patient placement criteria must address the unique characteristics of populations being served and of the treatment delivery system. The establishment of UPPC will help improve the system and help define what services are needed, but UPPC will not solve all cultural, political, and financial problems. While it is clear that uniform patient placement criteria can be valuable both locally and nationally, the benefits described in this chapter must be considered in light of several considerations.

Array of Resources

One immediate concern about the use of any set of patient placement criteria in a given geographical area is the availability of treatment resources. Not all areas will have the array of levels of care described in the criteria. In some cases, criteria can be adapted to fit the available resources. For example, in its outpatient criteria, Minnesota included an exception that allows the use of inpatient treatment when outpatient treatment is not within reasonable driving distance.

When the array of resources is adequate for most patients, there may still be gaps for patients who have unique characteristics or needs. Programs addressing the needs of members of special populations may be limited to offering one level of care because that is all the population can support. In the future, unbundling may alleviate some of the problem (see the discussion of unbundling in Chapter 3), but in the current environment, either the criteria must address these situations directly or the implementation must be flexible enough to allow for special circumstances.

While UPPC will help define the continuum of care, identify gaps, and facilitate filling those gaps, it is important that any lack of resources be identified and taken into account as UPPC are implemented.

Clinical Judgment

No set of criteria is likely to address the needs of every client. Rigid adherence to a set of criteria with, for example, four levels, could result in a "four sizes fit all" approach. This result would be only a marginal improvement over the "one size fits all" approach, predominant in the 1970s. The implementation of criteria must allow for flexibility on the part of clinicians to deviate from the levels of care to address the needs of the individual client.

A rigid or bureaucratic use of the criteria could result in placements made according to the criteria only, rather than on the treatment provider's knowledge of the client. For example, a clinician might place the patient in a higher level of care than the clinician believes is necessary, to avoid malpractice suits that might result if he or she deviates from the criteria. In other instances, a clinician might recommend placement in a lower level of care than is necessary due to the client's financial constraints, or because the clinician has difficulty describing the client's needs to fit the guidelines for a higher level.

While the panel recommends that scales and instruments be developed to assist in conducting multidimensional assessments, these tools are an aid to—not a replacement for—trained clinical judgment based on the clinician-patient relationship.

Program Development

Care must be taken to ensure that creativity in program development is not stifled by PPC. The criteria can describe the continuum of care only as it exists, or as sound research indicates it should change. However, the AOD treatment field is continually seeking ways to improve programs, and criteria should not force providers to fit molds or adhere to rigid descriptions of programs.

One benefit of UPPC will be the contribution they make to research findings, especially in regard to identifying elements of effective programs. Treatment providers can then incorporate these findings in their treatment services. While this is a benefit, it also creates a problem. The criteria must be revised regularly to incorporate new findings or they will become outdated. Outdated criteria would prevent, rather than promote, sound care.

Financial Incentives

The usefulness of UPPC will be severely limited in a payment and treatment delivery system that has financial incentives supporting over- or underutilization of specific levels of care. In Minnesota, at the time PPC were implemented, free or sliding fee treatment was available at residential units at State hospitals; however, no free or sliding fee outpatient treatment was available. PPC for outpatient programs were thus of little consequence for many clients until the funding system was changed.

Underutilization is a concern when funders are not held responsible for the outcomes of treatment, or are not at financial risk for repeat placements. Again using Minnesota as an example, there is concern that incentives are not encouraging managed care organizations to take long-term cost offsets into consideration in their provision of short-term care. As Minnesota moves to the use of managed care organizations to cover primary outpatient and inpatient AOD treatment for Medical Assistance clients, funds for extended residential treatment and halfway house services are provided by a separate, publicly paid system. This split responsibility for AOD treatment may have created the incentive for managed care organizations to divert clients to the public system.

Building Stakeholder Support

Uniform patient placement criteria can be proposed as a positive, proactive approach to improving AOD treatment services. They can be part of the organizational system of healthcare reform occurring in many States and may eventually be mandated for all States, counties, and regions. They imply a structured system of care with linkages to other systems and seamless movement among AOD abuse treatment and other medical and social services.

Before benefits can be realized, however, support is necessary from the many people involved in planning and providing AOD treatment. Support must come from the State, from public and private providers, from practitioners, from policymakers and legislators, from provider associations, from consumers, from managed care representatives, and from other third-party payers. Not only must all these stakeholders commit to the concept of UPPC, the reasons for their commitment must be clear and well articulated.

Although the most compelling reason for implementing UPPC is the enhancement of patient care, this conclusion is often reached "through a back door." It is frequently the cost-effectiveness argument that most persuasively convinces stakeholders of the value of UPPC, while improved patient care is viewed almost as a byproduct. For this reason, it is important to establish universal standards of care that serve to balance quality and cost effectiveness.

An early step in building support for uniform criteria is to adopt a biopsychosocial view of the concept of medical necessity. This panel recommends adopting a definition of medical necessity similar to that used by the American Society of Addiction Medicine in its PPC (Hoffmann et al., 1991). That definition reads, in part:

Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six biopsychosocial assessment areas of the patient. Because psychoactive substance use disorders are biopsychosocial in etiology and expression, assessment and treatment are most effective if they, too, are biopsychosocial.

This inclusion of patients' psychological and social as well as medical needs is a critical prerequisite for the inclusion of AOD treatment services under healthcare reform. Without such a broad and explicitly stated definition, the term "medical necessity" may be overly restrictive and may imply an incomplete understanding of addictive illness. In the current context of healthcare reform, the importance of defining healthcare broadly enough to include addictive illness cannot be overemphasized. A narrow view will not address the interests of many stakeholders.

Conflicts about adopting UPPC can pinpoint differences that may ultimately lead to constructive resolutions. All stakeholders should be included in the planning discussions, as they are a critical part of developing any policy or set of criteria. They are motivated by a variety of reasons, some political, some financial. Other stakeholders are concerned with shifting State priorities. It is important that State agencies and providers understand and consider each other's points of view. While one group of stakeholders may be looking at improved patient care and outcomes, another may be focused on cost savings. The more inclusive the process of developing UPPC, the more beneficial the process will be for all parties.

Concerned Stakeholders

The following groups of stakeholders should be considered in the support-building process:

- *State AOD agencies and policymakers* involved with healthcare reform have a unique responsibility in that they have a leadership role in balancing funding limitations with concerns for access to high-quality appropriate care.

- *Consumers and their families* have perhaps the greatest stake in the thoroughness of assessment and the appropriateness of placement.
- *Managed care companies and other public and private funders* require assurance that funds are being used wisely and that decisions about services are made objectively rather than in the self-interest of the provider. Improvements in the quality of treatment reduce incidences of relapse and the long-term need for other medical and social services.
- *Other healthcare providers, mental health professionals, benefits administrators and consultants, criminal and juvenile justice personnel, social service providers, and community advocates* have a major interest in ensuring easy access to appropriate care and in knowing when and where to refer. Improvements in the quality of treatment will reduce the human costs of AOD problems and the financial cost to other service delivery systems.
- *Professional societies* in the AOD treatment field will be more responsive to change and can help garner support if they are included in the dialogue.
- *State legislators* have complicated interests in that they are, in a sense, both policymakers and the general public. Legislators are often asked: What are you doing to solve the drug problem? The consistency and accountability that UPPC can provide for the AOD treatment field can furnish a valid response to the constituents' question.
- *Employers* that pay for employee healthcare coverage and their EAPs have a significant financial interest in the approach to treatment services.
- *Labor leaders and union representatives* have the responsibility of negotiating contracts that set care requirements for large employee groups and of protecting workers from unfair practices.
- *Utilization reviewers* have the responsibility to ensure that patient care is based on clinical necessity and severity of illness. UPPC will have an impact on the criteria used by managed care providers, who depend on utilization reviewers to monitor patient treatment records for adherence to the principles of appropriate care.
- *Medical ethicists* struggle with the uncertainty of the "right" answers to questions concerning medical policies or care. They are responsible for weighing facts and values to recommend ethically permissible options for a particular case. Their support is necessary to help providers deal with ethical issues relevant to UPPC.
- *Individuals and groups who conduct treatment research* have an interest in UPPC because they can use the criteria to help identify and prioritize areas of research that will help advance AOD treatment services and policy.
- *Native American leaders* have sovereign authority over regulating practices on their lands. Their AOD providers are treating a population that is unique in this respect, and they are usually working with minimal resources.
- *The general public* is concerned that little is being done to solve the far-reaching social and criminal problems that are caused by alcohol and other drugs. UPPC can provide confidence that appropriate and coordinated treatment services are in place and that tax dollars are not being wasted.

Support From the AOD Treatment Field

Clinical providers are an important part of the necessary "buy-in" to UPPC, and the States that have implemented uniform criteria have included providers in their planning process. Treatment providers have knowledge and experience necessary to the development of UPPC. In many cases, they are ahead of public policymakers in considering the important issues in implementation of UPPC.

Even as the value of sharper definitions within the AOD abuse treatment delivery system becomes apparent, these definitions can also be intimidating to the treatment community. By calling attention to the need for a complete array of treatment services, UPPC will set standards that individual programs must attempt to meet. Research on the efficacy of certain types of AOD treatment is sparse, and standards of care are not always well defined. The establishment of UPPC may have the effect of bringing a different set of policymakers to the table with new expectations about outcomes. These additional demands can result in new challenges and difficulties.

For these reasons, additional attention must be given to the interests of AOD treatment providers as the move toward UPPC evolves. Understandably, not all providers will react the same way to a proposal to implement uniform criteria. Those providers who have initiated the use of patient placement criteria in their programs will be valuable resources in a systemwide effort. However, other providers have not yet considered the use of PPC, and have not had the opportunity to examine the possible benefits of systemwide implementation.

In seeking support for UPPC, policymakers can rely on the interest of all providers in improving treatment for their clients. The most compelling reason for providers to support UPPC will be providers' enhanced ability to consistently provide thorough assessments, make appropriate placement determinations, and monitor clients' progress through the course of treatment.

AOD providers are fighting to be included in healthcare reform efforts, the redesign of medical service delivery systems, and financing systems in general. A compelling case for inclusion in the healthcare reform process can be built with the aid of a consistent set of UPPC. Many legislators and healthcare planners believe incorrectly that the AOD treatment field has no practice standards and guidelines for determining what type of treatment and how much treament is appropriate. This belief has led them to place inappropriate, nonclinical limits on care. UPPC will be important in moving toward parity with other healthcare providers in advocating for benefits.

Public programs often view patient placement from a different perspective than private programs. In many public programs burdened by long waiting lists, overextended resources, and the needs of a complex population, time-consuming discussions about patient placement are a lower priority than the need to provide immediate services. It is important that personnel in public programs appreciate that UPPC may eventually reduce the time required for proper placement decisions by providing an easily accessible framework for moving patients into and through a continuum of AOD treatment.

Treatment providers will also support the implementation of UPPC in the interest of protecting revenues and market share for their programs. Survival in the changing world of healthcare reform and managed care may require the use of UPPC. Managed care organizations have expressed a preference for contracting with providers that place clients in the least restrictive, appropriate level of care, and which use specific stay and discharge criteria. If, as in some States, patient placement criteria are required for licensing, the very existence of a program can depend on implementation of UPPC.

Use of UPPC can enhance services and facilitate resource reallocation throughout the continuum of care. Their use can also reveal where new services are needed. However, treatment providers and other professionals who fear that reallocation of resources will result in decreased funding for their own programs may see this as a drawback rather than a benefit. To gain their support, the likelihood of improved outcomes and long-term economic benefits should be emphasized.

As uniform criteria are adopted, providers may need help to restructure their services. Reallocation of resources does not necessarily mean that current providers will cease to exist and new ones will take their place. Providers that traditionally provided intensive services in highly restrictive settings may initially see a reduction in census. At the same time, there may be an increase in demand for a variety of outpatient resources. The experience of trained and committed treatment providers will continue to be needed and their services can be adapted to meet emerging needs.

At the time of implementation, some treatment providers may not be ready to support UPPC. They may simply be required to participate, through methods such as funding or licensing requirements.

Summary

To realize the benefits of implementing UPPC, it is crucial to garner support from a wide variety of stakeholders. The interests of each must be considered. A spectrum of reactions can be anticipated, ranging from advocacy to resistance, and a variety of strategies will be needed to obtain support.

Chapter 5—Implementation Strategies

In implementing any patient placement criteria (PPC) on a statewide or systemwide basis, a number of issues must be considered. What criteria will be used, and what modifications must be made to these criteria to take into account local resource distribution and special populations? How will the criteria be implemented (for example, as part of a payment system or through program licensing requirements)? Will the criteria necessitate changes in laws or administrative rules? Which agencies will have primary responsibility for making placement decisions? Who will need training? How will it be provided? Who will pay for it? What kind of ongoing technical assistance will be provided, and by whom? What are the funding sources for treatment? Will they impede the use of placement criteria? If so, can their limitations be changed?

In the States that have adopted patient placement criteria, the decision to implement was made by the single State agency (SSA). Stakeholder input was sought for the balance of the issues, although the responsibility for final decisions remained with the SSA.

This chapter addresses some of the considerations necessary for making implementation decisions.

Linking PPC to Licensing Regulations

Licensure requirements can be established by statute or rule and can include a requirement that a program adopt uniform patient placement criteria (UPPC) in order to obtain or retain a license. Montana has already implemented this procedure by describing levels of care in a statute. Treatment providers are then required, through licensing regulations, to identify the level or levels they provide and to adopt a system of PPC for appropriate placement. Licensure is also linked to eligibility for county and Federal block grant funds. Many hours of staff training have focused on learning the process of compliance with the regulations, which is supervised by onsite visits of State regulators. While still in the early stages of implementation and evaluation, the Montana model has largely achieved appropriate referrals and has been positively received. Oversight and staff training are seen as critical elements of this program, which have contributed to its success.

Other States have approached PPC and licensure differently. Massachusetts, for example, found that licensure and patient placement criteria initially conflicted and worked to align them, eventually making the conflicting requirements compatible. In another case, Minnesota wrote PPC in separate regulations but revised their licensing requirements at the same time, ensuring compatibility of requirements from the outset.

Linking PPC to Funding

The primary funding sources for AOD treatment are:

- State and Federal Government monies, including Medicaid and Medicare
- Private insurance (third-party payer)
- Self-pay.

Other less common sources include foundation grants, asset forfeiture, specific tax levies, and fines. Government sources can include Federal block grants and funds from the Indian Health Service, the Centers for Disease Control and Prevention (CDC), the Department of Veterans Affairs, and the Department of Justice, among others. One of the strongest arguments in favor of UPPC is the current reality that each funding source may dictate separate criteria for eligibility, admission, and continued stay.

There are several ways to successfully link funding requirements to UPPC, ensuring uniform implementation. Massachusetts linked placement criteria to the procurement process, so that vendors agreed to participate in the development and implementation of PPC in their agencies as a condition for funding. Another method is to require programs to have PPC in place to obtain Medicaid funding.

Private payers have their own PPC that may conflict with those of the SSA. This situation can be avoided by including the private payers in the planning process. In Montana, conflicts over duration and intensity of care issues between treatment providers and insurers were part of the impetus for developing the State's PPC. Blue Cross and Blue Shield of Montana collaborated with providers and the SSA on the development of PPC and now provides some of the compliance monitoring.

Minnesota's Consolidated Chemical Dependency Treatment Fund (CCDTF) is another method of linking PPC to the funding source. Before implementing the CCDTF, Minnesota used a combination of Medical Assistance, State-funded general assistance medical care, available Federal block grant funds, State hospital units, and county-funded programs to provide treatment for public clients. Each of these sources had separate eligibility requirements. Several provided for treatment only in a specific setting or level of care. For example, persons who qualified financially for State hospital programs could receive only residential care. Halfway house programs were available only to residents of certain counties. With the implementation of CCDTF, Minnesota pooled these funding sources so that placement decisions were no longer dependent on the funding source. Now, payment from the fund is authorized only for clients placed according to the State's PPC.

Range and Availability of Treatment Resources

Implicit in the concept of uniform patient placement criteria is the existence of an array of treatment services with varying levels of care. The actual range of treatment services is limited

by available resources and will have a significant effect on the implementation of UPPC. The existence of the entire continuum of care is not necessary to begin implementation. When resources are unavailable at the optimum treatment level, next-best choices on another level will be necessary. Providers responsible for placement must be aware of local treatment resources, the level(s) of care they provide, and available slots.

As discussed in Chapter 4, use of UPPC can clarify the need for a State to reorganize and reorient treatment services. Some established systems may need adjustment to fit the new criteria. For example, a region with most of its resources invested in hospital-based services may find that funds should be shifted to support development of a more diverse range of community-based residential and outpatient options. When providers become aware of a market for services currently unavailable, they are likely to respond by developing new services.

Resources can be inventoried to answer such questions as:

- Do the local treatment resources serve public or private patients, or both?
- What are the available levels of care?
- Do services exist to address the needs of special populations?
- Do services match the geographic distribution of patients?

The panel recommends that States develop a central directory identifying resources, levels of care, program availability, and detailed information about the programs, including specialized services and outcome data. A model for this directory can be found in the Target Cities project, which has established an automated system to track treatment services and slot availability. Other clinical management software has been developed (see Appendix B). A computerized directory can provide the most current information. However, treatment systems that do not have the resources or funding to develop a computerized directory can develop a manually implemented paper system, relying on frequent updates based on telephone communications.

Wraparound Services

Wraparound services enhance or supplement treatment services to meet patients' nonmedical needs. Family preservation services or transportation provided by a local department of social services are examples of wraparound services. A central resource directory can lead to referrals to wraparound services, which are often tied to programs. Wraparound services are an important adjunct to AOD abuse treatment and can be the key to successful treatment, although they are not usually considered treatment services in the clinical sense. The value of these services lends support to the concept that "medical necessity" is a broad multidimensional concept that goes beyond the narrow focus on physical and psychiatric severity.

When considering differences in cost, clinical treatment services should be distinguished from wraparound services, which may be less costly than medically managed services. Less intensive medical services will sometimes lead to better outcomes if they are combined with wraparound services that provide necessary social and logistical supports for patients. Wraparounds assist patients in learning to deal with real-life problems during treatment.

Inherent in the provision of wraparound services is some form of case management. Without case management, clients may have difficulty accessing services, or services may become fragmented.

Wraparounds can be divided into two categories: those that by their absence prohibit access or initiation of treatment, and those that are important to positive treatment outcomes. The first group of wraparound services may include:

- Childcare.
- Transportation. This issue can arise in several ways. In an urban area, it may mean getting the patient to the bus line and providing bus tokens for daily attendance at treatment sessions. In a rural area, it may mean transporting a patient out of his or her home community to obtain services that may not be available within hundreds of miles.
- Reading assistance for illiterate patients.

The second group of services usually addresses problem areas in the patient's life other than AOD abuse, although these problems may be closely tied to substance abuse. Provision of these services enhances treatment retention and promotes improved outcomes. They include:

- Primary healthcare, including screening and referral for HIV disease, tuberculosis (TB), and other infectious diseases
- Legal aid
- Mental health services
- Education
- Vocational training
- Liaison services with the Immigration and Naturalization Service
- Supportive living arrangements, such as recovery houses
- Financial assistance
- Services for victims of domestic violence
- Other social services.

In some treatment settings, wraparound services are already included. Therapeutic communities routinely provide many of the services listed above. Other programs have obtained special funding in order to include specific wraparound services. Federal block grant set-asides have been used to increase the availability of programs for women with children by paying for necessary wraparounds.

Studies on the value of wraparound services have documented the contribution they can make toward positive outcomes. For example, an Association of Junior League International study of services for women in 39 communities identified childcare as the most needed resource for women in treatment for alcoholism (Wilsnack, 1991).

Funding of wraparound services can be a complex issue. Usually, the primary funding for wraparound services comes from agencies other than the SSA, although the block grants authorize services such as referrals for treatment of HIV disease and tuberculosis. Other Federal agencies, such as the Department of Housing and Urban Development, provide some funding. State general funds often support wraparound services, as do State departments of corrections

and human services. Some costs of wraparounds may be covered by insurance companies or other third-party payers.

A barrier to obtaining needed wraparound services can arise if receiving a certain type of treatment makes a patient ineligible for needed services. For example, a mother can receive day care for her children if she is in a day treatment program in the community. Yet, if she is placed in a residential treatment facility, she may lose her eligibility for publicly funded day care. This example illustrates one of the potentially negative effects of differing eligibility requirements for services, as well as the need for coordinated, comprehensive care in a seamless system. It represents one of the challenges of implementing UPPC.

States may wish to consider a coordinated policy that defines the need, availability, and adequacy of wraparounds to complement AOD services. Typically, each of the agencies providing services has its own priority populations, which differ from agency to agency and State to State. It is up to the SSA to take a leadership role in making wraparound services for the AOD treatment population a high priority. Legislators need to be educated about the relationship between wraparound services and positive treatment outcomes, as well as the funding needed to make these services available.

In Minnesota, where PPC have been implemented, exceptions for situations in which rigid adherence to PPC would deny necessary treatment were clearly stated so that assessors would not be faced with the dilemma of placing patients in a level of care that would exclude them from needed wraparounds. Clearly, clinical factors alone do not determine placement. External pressures (financial, legal, or other) can drive placement to an inappropriate level of care. In the previous example, a mother would lose childcare eligibility if she were placed in a residential setting. The same example can be turned around to illustrate how placement can be driven to a more restrictive level: a woman may enter a residential setting when outpatient care is more appropriate, because the residential setting provides onsite childcare.

Coordination of multiple funding sources can have an enormous impact on the efficient use of UPPC. Since placement decisions may affect eligibility for wraparounds, the personnel making these decisions should identify ways to maximize support from other community agencies.

Needs of Special Populations

There are a number of special populations with needs that must be identified at assessment and considered in placement decisions. These populations can be defined in part by:

- Cultural background
- Language spoken
- Rural, suburban, or urban background
- Gender
- Age
- Employment status (for example, chronically unemployed or underemployed)
- Living situation (including homelessness)
- Childcare responsibilities and/or pregnancy

- Dual diagnosis of mental illness and addiction
- Criminal justice issues, including incarceration, parole and probation, and DWI offenses
- Sexual orientation
- Mental retardation
- Physical disability, including visual and hearing impairment
- Illiteracy or a learning disability.

The characteristics of patients in these groups will have an impact on the implementation of patient placement criteria with regard to level of care, level of intensity, and length of stay. If there is a need for additional support services, special populations may require flexibility in the use of UPPC. Others may require intensified case management. Some programs do not have the ability to meet these needs. For example, seriously mentally ill patients, with their high relapse potential, may require mental health services that AOD treatment providers are not qualified to give. Adolescents placed in an adult program are not likely to receive the specialized treatment or social services they need; likewise, the elderly may need services that are not traditionally offered by a program serving patients in their 20s and 30s. Members of special populations may benefit from completely different types of treatment or from services provided by members of the same population group.

It is important to be aware that while specific populations often share a constellation of common needs, there are individual needs as well. It is a disservice to treat all those in a special population as if they have the same needs.

Factors that should be addressed for special populations include:

- Access to services
- Patient willingness to participate in treatment
- Need for specialized services
- Increased stress on the program to deliver specialized services
- Longer lengths of stay
- Need to make links to appropriate services that will follow AOD abuse care.

Efficient coordination of services for these populations can be accomplished in several ways. The least efficient way for the patient to receive services is to travel from one agency to another (for example, to social services or public housing) to establish eligibility and apply for services. Some States have established a "one-stop shopping" approach, with representatives from a variety of agencies present at the location where AOD services are coordinated. In some jurisdictions this process is even more streamlined, with one application form that can be completed to obtain many available services.

Patients with multiple needs for wraparounds are also likely to need intensive case management. Active case management provides another model for coordinating wraparound services with AOD abuse treatment.

The Relationship Between Eligibility Criteria and Patient Placement Criteria

Eligibility requirements are the first determination in patient placement, overriding and taking precedence over all other considerations, including UPPC. Eligibility criteria establish whether patients can get into the systems of care that are governed by UPPC. A patient's involvement in the criminal justice system is one determinant of eligibility for placement. Offenders who are incarcerated are obviously ineligible for referral to a community-based outpatient treatment program.

The steps of sequential assessment for placement can be described as:

- Eligibility determination
- Screening (deciding whether a patient needs AOD treatment services)
- Level of care determination (where the patient is referred)
- Treatment service selection (what specific type and intensity of services the patient receives within the placement).

The eligibility structure that represents current policy in most States is largely dependent on funding source. Other factors include: insurance, age, State or Federal priority populations, and whether or not the patient enters treatment through the criminal justice system. State regulations are also a consideration. For example, in Georgia, both low income and severity of illness must be factors for a patient to receive the highest level of priority for public programs. Additionally, the Federal Government requires States to set aside a portion of their Federal funds for certain types of programs or for services to a special population. Federal block grant set-asides limit the funding available (and therefore access to services) to population groups not covered by the set-asides. In most cases, the services for which a patient is eligible will directly influence that patient's placement and care.

Eligibility criteria are not only financially determined, but dictated in part by geographic considerations. Patients in one jurisdiction may be ineligible to receive services in another, even if those services better meet their needs.

Programs established to serve special populations are often limited to a specific level of care. Program specialization tends to override PPC, particularly for clients who fit well into the niche described by the specialization. To illustrate, if the only program in the client's native tongue is residential, the client will most likely be placed in residential treatment, even if PPC are not satisfied by the placement.

Other eligibility requirements are linked to the requirements of third-party payers. If an insurance company will pay for only 7 days of inpatient treatment, that limitation may override PPC recommendations. If managed care lengths of stay expire, so too will eligibility for placement, unless public-sector services are available for these patients. These are constraints that can limit the universality of PPC and raise ethical issues as well. Negotiation and mediation will be required as the dialogue on UPPC progresses.

This panel notes that rigid eligibility requirements will interfere with the implementation of UPPC. If eligibility alone dictates placement, an appropriate level-of-care determination is difficult at best. The panel recommends that all patients enter the AOD treatment system at the same level of eligibility. In other words, eligibility and patient placement criteria should be merged.

Single State agencies can influence such eligibility policies, particularly when requirements are established by providers that the SSA funds. It is important that consensus on these issues be reached by policymakers, and that nonclinical caps for treatment eligibility be prevented from undermining the integrity of a uniform PPC system.

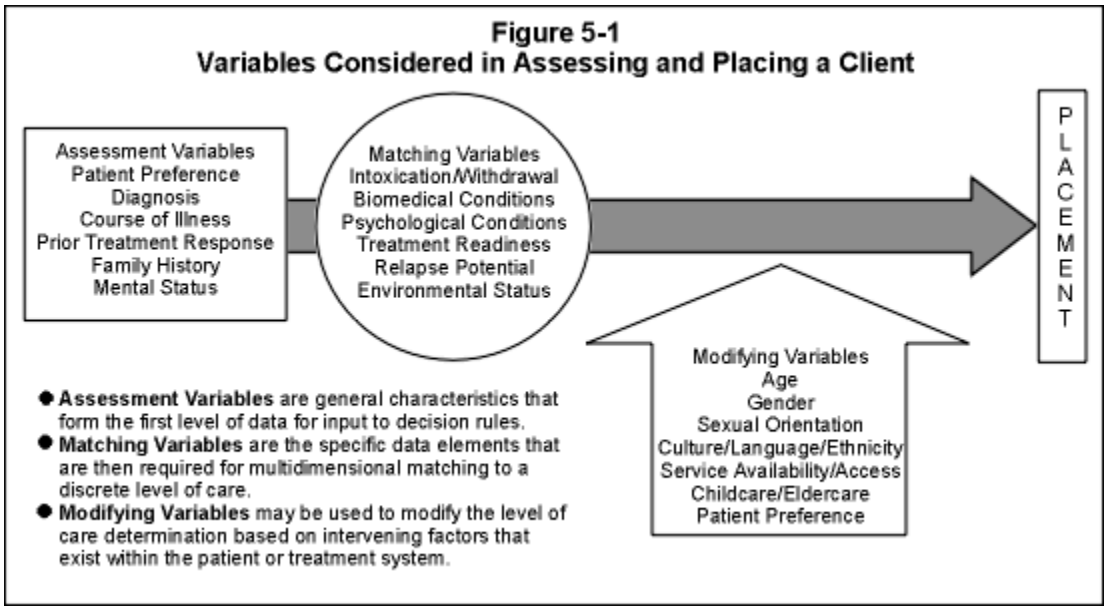
An approach that States can use to merge eligibility requirements and PPC is the examination of aggregate AOD treatment needs of its population. The number of patients needing services at each level of care—including patients moving from one level to another—can be estimated using UPPC, as described in Chapter 4. These estimates can form the basis for an approximation of the overall cost of AOD treatment. These statistics can be presented to State legislators or other bodies making policy and funding decisions—along with statistics about the cost of implementing UPPC and financial offsets of AOD treatment. It will then be apparent that treatment costs for substance abuse treatment are measurable and can be clearly defined by an appropriate system of placement.

States can also tie eligibility criteria to UPPC, funding individual admissions rather than contracting for a specific service from a treatment provider. Usually, public treatment is funded by a contract for a specific number of beds, admissions, or slots in a level of care. It is through the existence of multiple contracts that an array of services is offered. An alternative is to fund an individual client for a specific level of care, much as fee-for-service insurance and Medicaid operates. The appropriateness of the service could then be determined using PPC. Minnesota's Consolidated Chemical Dependency Treatment Fund described earlier in this chapter is an example of the successful implementation of such a strategy.

Assessment

Assessment for the purpose of placement for AOD treatment is a complex process involving an individualized, multidimensional approach for each patient. The American Society of Addiction Medicine (ASAM) patient placement criteria define assessment as "those procedures by which a program evaluates an individual's strengths, weaknesses, problems, and needs, so that a treatment plan can be developed" (ASAM, 1991). Another definition of assessment comes from the Institute of Medicine, which describes assessment as "the systematic process of interaction with an individual to observe, elicit, and subsequently assemble the relevant information required to deal with his or her case, both immediately and for the foreseeable future" (Institute of Medicine, 1990).

The process of assessment has long been recognized as a critical element in providing effective AOD abuse treatment.



Public and private developers of patient placement criteria have recognized this fact by placing assessment at the core of their criteria. All those involved in implementing UPPC should understand the central importance of assessment and its place in AOD abuse treatment. Many Treatment Improvement Protocols (TIPs) in this series describe assessment and related issues. Three TIPs address assessment of special populations—*Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, *Assessment and Treatment Planning of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*, and *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*. The TIP *Matching Patient Needs in Opioid Substitution Therapy* (in development) has a chapter on conducting ongoing assessments during methadone treatment to match patients with needed wraparound services. The TIP *Screening for Alcohol and Other Drug Abuse Among Hospitalized Trauma Patients* (in development) discusses the importance of careful AOD assessment in preventing devastating injuries.

The Center for Substance Abuse Treatment has noted that the following elements, consistent with the biopsychosocial perspective, should be included in a model assessment:

- Medical examination
- Alcohol and other drug use history
- Psychosocial evaluation
- Psychiatric evaluation (where warranted)
- Review of socioeconomic factors
- Review of eligibility for public health, welfare, employment, and educational assistance programs.

There are two basic (and sometimes overlapping) goals of assessment: to determine patient placement, and to determine an appropriate treatment plan. There are important distinctions

between assessment and the concept of PPC discussed in this TIP. Assessment is an individualized process. PPC describe gross characteristics that lead to a recommendation for a level of care. Once a placement decision is made, the PPC serve as a foundation for individualized treatment planning.

As shown in Figure 5-1, patient placement is based on a process of assessment that considers three sets of variables: assessment variables, matching variables, and modifying variables. Using patient placement criteria, the clinician moves from the most general information about the patient and the patient's addiction through a set of variables that match the patient to a discrete level of care to a set of intervening variables that may modify the level of care determination.

Assessment is an ongoing, cumulative process that can provide certification to authorize certain levels of care, particularly if reimbursement is to come from a private entity. As a patient moves from one level of care to another, one assessment builds on another, leading to a discharge plan. Again, a number of different models exist for these phases of assessment, and the addition of managed care to the equation has meant a rapidly changing landscape in this regard.

This TIP panel believes that there is room for a variety of assessment models among the various States and AOD treatment systems. These can range from decentralized, provider-driven models to the central intake and assessment agencies that some States have set up. One model of the decentralized form of assessment is the Target Cities program, which provides services to populations in metropolitan areas at greatest risk for AOD addiction. The program has at its core comprehensive independent assessment evaluation from treatment providers, including physical examinations, psychological testing, and placement criteria.

Each State must evaluate its own needs to determine how resources can best be used in the assessment process. This evaluation process is related to the issue of building organized systems of care, a critical issue in healthcare reform.

Urban systems handling large numbers of patients are likely to have more comprehensive assessment systems than smaller rural systems, which may depend on informal evaluations by public health or criminal justice personnel to place patients in treatment.

Staffing and Training Considerations for Assessors

Because of the increasing complexity of patient profiles, assessments are best performed by professionals highly trained in comprehensive evaluation. Unfortunately, AOD treatment is a profession with a high rate of personnel turnover, particularly in the public sector, where intake workers may be relatively inexperienced. In many systems, the least skilled personnel do assessments, while more highly trained clinicians resist intake work.

When UPPC are being implemented, it will be necessary for intake and assessment workers to be thoroughly trained in the use of the criteria. While the training of these personnel may be the highest priority, all staff must be trained. This will ensure that the benefits of continued stay criteria and individualized treatment planning are realized.

The training must include:

- Information on the benefits of UPPC, both for the delivery system and for individualized patient care
- Specific skills in assessment, the application of placement criteria, and documentation
- Emphasis on the important role of clinical judgment in assessment
- Assessment and placement issues for special populations.

To some degree, the nature of training will depend on the methods by which UPPC are being implemented and the qualifications of the assessors. For instance, if the professionals given the responsibility for assessing and making placement decisions are credentialed AOD counselors who are already doing assessments, the training could focus on the specific placement criteria. For corrections department, human services, or mental health professionals who are inexperienced assessors, the training may include discussion of the nature of AOD use and the treatment delivery systems, as well as the placement criteria. Each State, depending on its resources and implementation plan, must set the specific minimum education, experience, and training requirements for assessors.

When implementing a new public policy that requires significant training, the States can expect to underwrite a substantial portion of the cost. Training will probably be the most expensive aspect of UPPC implementation. It is also true that programs and individual professionals have a responsibility for continuing education. Existing program budgets for training of personnel can defray some of the expense.

Strengths and Weaknesses of the Settings in Which Assessment Occurs

The essential question in choosing the setting for placement decisions is whether to rely on AOD treatment providers or to use agencies with some degree of separateness from the treatment provider. The decision must be made on a State level, based on knowledge of the treatment community and the availability and accessibility of the resources.

The primary arguments for independent assessment is concern about AOD providers having a conflict of interest and the likelihood that the independent assessor can draw on a wider variety of treatment programs.

The primary argument for relying on treatment providers for assessment is continuity of care. Assessments can be more readily linked to individual treatment plans. If assessment information from an independent assessor is not relayed to the treatment provider quickly, the client may have to undergo another assessment.

Many States will find that mixing and matching assessment settings will best meet their needs. A State may, for example, prefer that detoxification programs perform assessments, but many localities have no such dedicated programs. Therefore, this State may permit local social service or public health agencies to perform assessments.

Regardless of the setting(s) chosen, individual clinicians may prefer to refer patients to programs or treatment modalities with which they are well acquainted. The existence of UPPC may not necessarily avoid this dilemma. Ongoing technical assistance, monitoring, and treatment review will be necessary to ensure consistent implementation of assessment and placement standards.

Treatment Programs

An important strength of treatment programs as a setting for the assessment process are the qualified addiction treatment professionals on staff who can learn to use UPPC. In addition, the treatment provider is often sensitive to cultural and local community issues. Another advantage of conducting assessments in treatment programs is that less duplication of effort occurs in treatment than when separate entities perform assessments, as the information obtained can be used immediately for treatment planning.

However, these strengths have parallel weaknesses. Some programs may not have staff members who can deal with issues of cultural sensitivity or the concerns of special populations. Less comprehensive treatment programs will have less comprehensive resources to lend to assessment.

A major problem with assessments performed by treatment programs is the possibility of conflict of interest. Placement decisions may have implications for a program's success in filling its treatment slots. Also, in organizations that offer multiple levels of care, there may be a temptation to place patients at the most expensive level. While professional substance abuse personnel can be expected to make placement decisions based on best practice and the patient's best interest, these can be compelling pressures, particularly in the current atmosphere of financial uncertainty.

The impact of these issues can be minimized by individual programs establishing—and using—internal policies and procedures in which the expectation is that client assessment will determine placement. Providers can then establish internal quality improvement indicators to evaluate the appropriateness of placement decisions. There are already parallels to this with the "at risk" managed care organizations and capitated contracts.

Detoxification Services

Detoxification services have a unique opportunity to identify individuals who need AOD abuse treatment. Many persons who eventually receive AOD treatment are first screened and assessed when undergoing detoxification from alcohol or other drugs. Detoxification service sites may also be used as assessment sites for anyone needing AOD treatment. One advantage is that those who are in danger of or experiencing severe withdrawal, for which specific detoxification services are clinically indicated, can receive an immediate referral. (Another TIP in this series, currently in development, is *Detoxification From Alcohol and Other Drugs*, which provides a detailed examination of detoxification services.)

A body of AOD abuse treatment literature has found that the assessment process should occur at the first intervention point. This is another advantage of performing assessment while a person is

receiving detoxification services. During this period, the individual may engage in self-evaluation and reexperience feelings of crisis, leading to an appreciation of the seriousness of the AOD problem. This can be considered a "teachable moment."

There are some drawbacks in performing assessments at sites that provide detoxification services. First, rural areas often lack dedicated detoxification centers. Second, across the country, many detoxification services are provided in acute care hospitals. Many of these hospitals do not have staff who are trained in AOD assessment or treatment and many physicians lack sufficient training to adequately assess their addicted patients' needs. Third, many people who need AOD treatment do not enter the system through a detoxification center. Some receive detoxification in outpatient settings. Whether or not detoxification settings can perform assessments depends on staffing and other resources.

Managed Care Organizations

Managed care organizations may have a role in assessment in several different models. An example is an organization that manages an employee assistance program (EAP) for a business, performing initial assessments and referring for treatment.

Some managed care organizations do not have face-to-face contact with patients. Involving these organizations in the assessment process can provide this contact between the patient and the organization, a human element that is often missing in the managed care environment. A weakness of this model is that most managed care organizations are not licensed for substance abuse programs.

Some managed care providers have, or contract for, trained staff to perform assessments. This approach may have some disadvantages, as the involvement of more personnel contributes to the separation of assessment and treatment planning. This problem is avoided by managed care providers who not only have trained assessment staff, but also operate their own treatment centers.

A major weakness in using managed care providers as the primary assessment resource is that they, like treatment providers, may have a conflict in that they have an interest in placing the patient in the least expensive, least intensive level of care.

Public Funders and Agencies

In some States where most providers of services are private, assessment may be the primary role of the public sector. The underlying philosophy of this approach is that assessment and oversight are where the public interest is preserved, while the State removes itself from the actual provision of services.

A major advantage of this assessment model is that it reduces the potential for conflict of interest. When public agencies are involved, the process is open to public examination and input.

Assessments may be done at agencies such as departments of public health, mental health, social services, and criminal or juvenile justice. Since criminal and juvenile justice personnel have many clients who need AOD treatment, it may be appropriate for such agencies to perform assessments, as they are often familiar with the patient's history and have a sound basis for their treatment recommendations.

Assessments for public clients in Minnesota are provided by county social service agencies and American Indian tribal alcohol and substance abuse programs. Each has specially trained assessors. Assessments are accepted from treatment providers only when the provider has specific expertise in working with a special population or when the county agency is too small to have a trained assessor. When an assessment is performed by a treatment provider, the placement decision is reviewed by the county.

The Target Cities programs provide another model for using an independent assessment model for public clients. A strength of this approach is that assessors are not invested in placement and have little conflict of interest. It also offers an easy point of access into the AOD treatment system. Assessors are specialists in assessment, ensuring that assessments will be performed consistently, systemwide. Assessment by independent agencies may simplify the task of collecting aggregate data.

A weakness to this approach is that when agencies such as mental health and criminal justice become involved in assessment, there can be disagreement about priorities, the process can become unfocused, and fragmentation and inconsistency of services can result. Strong interagency agreements specifying the responsibilities of each agency are essential to coordinating services. Oversight and review are necessary to ensure adherence to standards.

A second disadvantage of this public sector approach is the deterrent effect for some patients because of the association with the enforcement side of government. For example, some women may not want to become involved with a State assessor because they fear their children will be taken away from them once their AOD abuse is known. This critical obstacle prevents some women from seeking or entering treatment. Likewise, fear of incarceration may keep people from revealing information about illicit drug use to a State assessor. In these situations, it is crucial to strictly comply with Federal confidentiality regulations.

Another weakness is the potential duplication of services and the fact that assessment by independent agencies may add another provider to the process. Each additional provider means something else to fund. It is also another potential drop-out point for the patient. Reliance on agencies that are not primarily AOD treatment providers has major implications for staffing in those agencies and for the State's training plan.

Assessment Instruments and Tools

Most current assessment tools do not relate directly to patient placement decisions. Adoption of uniform patient placement criteria will probably lead to the development of more instruments that match agreed-upon assessment dimensions.

A few tools are under development, but they must go through the rigors of reliability and validity testing before they can be used on a widespread basis. Tools should be readily usable by professional staff, providing semiquantitative results that match the various dimensions of the PPC, and should be available in different languages. Automated tools facilitate data collection, ease of administration, and transfer of information in a system. Data from assessment tools should link to treatment outcomes.

Ideally, an instrument should involve a patient interview. The use of an instrument should not be seen as a substitute for the patient interview, which should validate the findings of the instrument. If an assessor focuses wholly on the instrument, it will limit the scope of information obtained.

Some instruments exist that correspond with specific PPC. For example, the Clinical Institute Withdrawal Assessment for Alcohol—Revised (CIWA-Ar) is useful to measure Dimension 1, acute intoxication and/or withdrawal potential as described in the ASAM PPC. For Dimension 2, biomedical conditions and complications, there are no quantitative scales, although the Addiction Severity Index (ASI) does have a medical category. A medical history, a physical examination, and laboratory tests provide the best information to measure this dimension, and special attention should be paid to physical conditions associated with AOD use, such as liver disease or HIV disease.

Dimension 3 addresses emotional/behavioral conditions or complications, which can be measured by the psychiatric or psychological scales on the ASI. There are a variety of psychiatric diagnostic and severity scales, many of which provide useful information but none of which correlate directly with the ASAM PPC.

There are only a handful of instruments that measure Dimension 4, treatment acceptance/resistance; Dimension 5, relapse potential; or Dimension 6, recovery environment. Some existing tools include the ASI, the Level of Care Index (LOCI), and the Recovery Attitude and Treatment Evaluator (RAATE). More information on these and other assessment instruments is included in Appendix B of this TIP. The other TIPs on assessment mentioned at the beginning of this section describe a variety of useful instruments.

Summary

A number of important considerations must be examined when discussing implemention of UPPC. Some of these issues include:

- Tying UPPC to licensing requirements and funding sources
- The relationship between UPPC and the actual range and availability of treatment resources
- Wraparound services
- Factors that should be addressed for special populations
- Possible conflicts of eligibility requirements with UPPC
- Elements and goals of assessment

- Staff and training needs for assessors
- Strengths and weaknesses of various settings for assessments
- Assessment instruments and tools.

Chapter 6—Future Directions: National Implementation and New Research Opportunities

As healthcare reform moves forward, adoption of uniform patient placement criteria (UPPC) on a national basis may help ensure consistent access to appropriate care for persons needing alcohol and other drug (AOD) abuse treatment. The statewide benefits of UPPC outlined in Chapter 4 are just as applicable on a national level. In addition, with national criteria in place, States' resources can be focused on implementation and oversight rather than on development. Using the national criteria as a base, States need only develop adaptations to reflect local special populations or resource configurations. The more comprehensive the national criteria, the less local adaptation will be necessary.

Currently, the major managed care providers cover enrollees in several States and use companywide criteria. Use of one set of criteria in all States will increase the likelihood that managed care providers will use UPPC.

This chapter discusses the process of developing support for the national implementation of UPPC and suggests strategies for implementation. Several immediate tasks are outlined that are necessary to overcome the barriers to acceptance of uniform criteria by the AOD abuse treatment system and stakeholder groups. Recommendations are presented for the formation of a national advisory panel to guide the consensus-building and implementation process and to play a continuing role in the refinement of UPPC. Suggestions about the panel's responsibilities and funding sources for the panel are discussed.

Those who are working to implement UPPC should have a thorough understanding of the role UPPC will play in research. Widespread use of UPPC will allow investigators to design and conduct the types of careful, narrowly focused studies that are needed in the AOD treatment field to demonstrate treatment effectiveness and cost effectiveness. The second section of this chapter describes areas of research that will be aided by adoption of UPPC.

Developing Consensus and Implementing UPPC on a National Basis

An important step in developing UPPC is to establish consensus within the treatment community and among other stakeholders with regard to the strengths and weaknesses of existing criteria sets. A uniform set of criteria can then be developed based on the best features of established criteria—with short-term efforts focused on filling in gaps and creating missing elements, and long-term efforts focused on addressing new treatment modalities and populations.

However, no consensus currently exists about the patient placement criteria (PPC) now in use. As discussed in Chapter 3, several States have developed their own criteria sets, which they believe more adequately address the needs of patients in public-sector treatment systems. Private

healthcare organizations have also created placement criteria based on their approaches to treatment and on the characteristics of the clients they serve.

Not only is there a lack of consensus about current patient placement criteria, but there also is a wide disparity in the level of knowledge about criteria among AOD abuse treatment providers. Many providers have developed hands-on knowledge by operating within a PPC framework and therefore understand the importance of uniform criteria in the current healthcare environment. Others in the field have not worked in such a framework or given much thought to UPPC as a common base for providing treatment. A primary goal of this Treatment Improvement Protocol (TIP) is to educate treatment providers about the use and current status of PPC.

Immediate Tasks

Several immediate tasks must be addressed in order to develop consensus within the AOD treatment field—and among other stakeholders—on existing criteria, and to move toward the establishment of uniform criteria.

The Need for Data

The most important task is to accumulate and analyze comprehensive data about the effectiveness of PPC in improving the quality of AOD treatment and in reducing the cost of treatment. Even the most comprehensive and carefully detailed criteria cannot gain wide acceptance among treatment providers, payers, and other stakeholders unless there is empirical evidence that implementing the criteria will accomplish expected goals. These goals include improved treatment and access to care, more efficient delivery of treatment, and cost savings. Validation through research is a crucial step in the process of establishing UPPC. However, carefully designed, large-group studies often take several years to complete. Other tasks must be addressed in the interim.

The Need to Educate Treatment Providers About UPPC

A second key task is to continue to familiarize treatment providers with patient placement criteria—how they are used and how they are related to the forces at work in the current healthcare environment. One strategy would be to develop and distribute an information packet about the advantages of adopting UPPC. An important point to be emphasized is that the creation of less expensive levels of care and more appropriate and effective placements achieved through the use of uniform criteria will result in improved treatment outcomes and significant cost savings.

Another strategy to promote understanding would be the dissemination of existing criteria and the use of forums to discuss their strengths and weaknesses. Treatment providers' concerns about the implementation of new criteria could be openly addressed. An important point to be emphasized during this effort is that the criteria should reflect the knowledge and experience of the entire treatment community and the many disciplines it comprises.

An immediate task at hand is to recognize that all systems resist change—even positive change—and that providers and other stakeholders will need help overcoming their resistance to using placement criteria. Each stakeholder group has its own reasons for wanting to maintain the status quo, and it is critical to understand and include these points of view in the consensus development process. A particular

discipline, a particular type of treatment organization, or providers in a particular geographic area may have valid questions that cannot be overlooked. Such questions may include: "These criteria may work for you, but do they apply to us?" "Do they recognize our unique organizational needs?" "If we accept them, what will it mean in terms of our ability to continue to provide good treatment or even to continue as a provider entity?"

Immediate Tasks for Developing Consensus Among Stakeholders

- **Accumulate and analyze data on the effectiveness of PPC**
- **Continue to familiarize treatment providers with information on PPC**
- **Develop criteria which are relatively easy to use and implement**
- **Include all stakeholder groups in the consensus process**

These and other questions that might be posed relate to the general applicability of the criteria. The heterogeneity of the AOD treatment population has been increasingly recognized. Particular subgroups of patients have specialized treatment needs, and developing a uniform set of criteria that takes into account a wide spectrum of needs is a unique challenge that must be addressed in the short term.

Ease of Application

It is also important to ensure that the criteria are relatively easy to use and implement. User-friendly criteria are more likely to gain acceptance. In addition, the framework on which the criteria are based should not be unnecessarily complicated and should be based on current concepts of treatment. The criteria must lend themselves to the use of checklists, flowcharts, and quick-reference guides. Treatment providers will be unwilling to refer to lengthy documents or complicated lists of categories and subcategories.

The Role of Payers and Legislators

The consensus development process should be as inclusive as possible of all stakeholder groups. A detailed discussion of stakeholders' interests is included in Chapter 4, but it is worth noting here that given the realities of today's healthcare environment, the education of payers and legislators must be considered an important part of the process. A uniform set of placement criteria can provide the structure for a high-quality continuum of care. However, if payers do not

recognize their worth and refuse to pay for services, and if Congress and State governments do not create mechanisms by which the continuum can be established and maintained, efforts to develop uniform criteria will not achieve the desired results.

Strategies for Developing National Support

Chapters 4 and 5 include detailed discussions of the benefits of UPPC and of strategies to build statewide or systemwide support for adopting uniform criteria. The same strategic issues must be addressed at the national level to gain support for UPPC. This section highlights points in the earlier discussions of the benefits of UPPC and strategies for implementation. The concept of a national advisory panel is presented.

Because UPPC is a complex issue involving a large number of participants, several strategies will be necessary to gather support for implementation. Strategic planning should be viewed as part of a consensus-building process that includes substance abuse treatment in the overall plan for healthcare reform and that addresses the onset of managed care.

Stakeholders should understand that adopting uniform criteria may be necessary for survival in the rapidly changing healthcare field. Emphasizing the importance of UPPC in the context of economic survival will bring stakeholders to the table. They will be invested in succeeding with the systems that will be put in place. Adopting UPPC and using them for appropriate patient placement can be proposed as a positive, proactive alternative to a "wait and see" approach and will prevent the failure of programs and the denial of treatment for some patients.

An effective starting strategy might be the preliminary implementation of uniform criteria in a system that does not hold providers responsible for following through on the dictates of the criteria. In other words, some providers may be reluctant to become involved with a system that, in effect, requires them to place patients in programs that do not yet exist, or to which they have no access. Providers can first be asked to simply collect the aggregate data generated from using UPPC over a specific time period. The data can then be used as a means of demonstrating to policymakers that some patients are not receiving needed services. Using this approach, providers may wish to become involved, as UPPC then will not be perceived as an imposed mandate that is difficult or impossible to implement.

Another issue to be emphasized is the role of UPPC in bringing stability to the AOD treatment field. The idea of bringing consistency in treatment to a field that is perceived to be in turmoil can be particularly attractive to legislators who may have to defend their support of alcohol and other drug programs.

It is useful to demonstrate the increased financial support that can be generated from revenue savings and better use of resources. While implementation of a new process may at first seem to be a costly proposition, it can be demonstrated that these costs will ultimately be offset by savings.

Another strategy to gain support is for UPPC designers to align with national groups such as the American Society of Addiction Medicine, the American Psychiatric Association, the National Treatment Consortium, State medical associations, the American Nurses Association, the American Psychological Association, the National Association of Alcoholism and Drug Abuse Counselors, the National Association of Social Workers, counselor associations, and provider associations. Professional endorsement lends credibility to the process. Also, many members of these professional organizations work in programs and are treatment providers, so their support will spread to their peers in the field.

A National Clearinghouse

Until new UPPC are available, there is a need for a national clearinghouse that would give States or other organizations that are developing uniform criteria access to the available models. The Alcohol and Other Drug Authority in Iowa is currently performing this function for other State agencies. Such a clearinghouse on the national level could be placed with an organization that ultimately takes on the responsibility for developing the next generation of UPPC. The National Center for Addictions Treatment Criteria at Harvard Medical School may also be appropriate to fulfill this function.

A National Advisory Panel

A national advisory panel should be established that represents stakeholder groups. The panel would have several functions and the composition of its members might evolve over time. The functions of the advisory panel would include:

- Ensuring representation from interested stakeholders
- Establishing linkages to healthcare reform efforts
- Developing consensus on existing criteria sets
- Establishing an evaluation plan to test the validity of the criteria
- Providing guidance for the direction of research
- Integrating new research findings and updating UPPC
- Setting training objectives for the implementation of UPPC
- Developing criteria that move beyond placement decisions to the actual matching of patients to specific modalities and services.

Functions of the National Advisory Panel

Initially, the main function of the panel should be to develop consensus about existing criteria. To facilitate the participation of all stakeholder groups, each SSA could be invited to form a workgroup representative of the stakeholders in that State. The workgroups would respond to draft criteria generated by the national advisory panel. The panel could then consider the feedback from the State groups and draft a revised set of criteria. This process could be repeated until reasonable consensus is reached. Extensive use of electronic mail and bulletin boards, as well as the use of teleconferences, could facilitate wide participation at minimal cost.

An important consideration for the panel will be the effectiveness of criteria currently in use as demonstrated by the available empirical data. Multidisciplinary representation on the panel throughout this process is crucial. The criteria will have more relevance if the panel represents the input of individuals with clinical expertise in a broad range of treatment modalities, as well as those with expert knowledge of the overall treatment system, including the realities of managed care, third-party reimbursement, Federal financing, and healthcare reform. Diversity among panel members will help ensure that the resulting set of criteria reflects best practices and achieves the goal of reducing costs.

Criteria Evaluation

In the current environment, sets of PPC are proliferating rapidly within treatment programs, managed care organizations, and, in some cases, within individual SSAs. This can be confusing to treatment providers and consumers, can create friction between providers and funders, and can contribute to reduced credibility among professionals and policymakers outside the AOD abuse treatment field.

Ideally, before UPPC are implemented, field trials and other research would be undertaken to test the validity and reliability of the criteria. Based on the empirical evidence, the criteria would then be refined and prepared for implementation on a larger scale. However, the need for UPPC supported by broad consensus is immediate.

Therefore, the development of UPPC must include implementation and evaluation planning. It is recommended that the national advisory panel be responsible for the evaluation plan. It should include studies to assess the validity of the criteria with different populations and the reliability of the criteria when they are applied by various providers in a range of settings.

The next generation of UPPC must be based on all the available empirical information, and care must be given to update the criteria as research, feedback from patients and providers, and new developments in treatment become available.

Training Objectives for the Implementation of UPPC

Training in the use of UPPC will be essential, and the national advisory panel should coordinate the development of a uniform training package that highlights key concepts in every training session. This training should include:

- The benefits of UPPC
- The framework or structure of UPPC
- Specific skills training in applying UPPC with a variety of patient profiles
- Information about the needs of special populations as it applies to gathering assessment data and making placement decisions.

If clinicians understand the purpose of UPPC and its core elements they can apply the information more effectively.

Funding for the Advisory Panel

The panel will require professional and support staff supplied by a permanent organization. Reliable funding is essential. Creating a broad base of support and developing consensus requires funding from a source that shares the goals of stakeholder groups.

Because the task of reviewing criteria and making recommendations about their acceptance would be the panel's chief function, agencies that fund research bearing upon the criteria should not be involved in funding. A longer-term process similar to the one used to develop TIPs—making use of multidisciplinary consensus panels—may be used to develop the next generation of UPPC.

Such a process would ensure the involvement of many stakeholders and grant legitimacy to the resulting criteria. It would differ from the TIP process in that it would involve a series of meetings, allowing participants to reflect, gather resources, and consult with other interested parties. As will be shown in the discussion to follow, developing the next generation of uniform criteria to structure the treatment field and ensure the involvement of payers and legislators may be a discrete, time-limited step in efforts to improve the efficiency of AOD treatment. Hence, such funding may be relatively short term. Obtaining funding for a limited period and to meet certain agreed-upon goals may be easier than seeking funds for an ongoing, indefinite process.

A public and private partnership involving funds from the Federal agency or agencies and from other stakeholder groups is a possible alternative.

The funding agency or groups could nominate individuals from the stakeholder groups to serve on the panel. It is important to include consumers since they are the ultimate assessors of the quality of services. Once initial criteria are in place, the panel would meet periodically and researchers who were conducting studies related to the criteria would present their findings for review. In determining how often an advisory panel should meet, consideration should be given to the fact that careful empirical studies are long term and that sufficient new data might not be available to justify meeting more than once or twice a year.

A report of the proceedings from the panel's review would perform the important function of disseminating the panel's recommendations about changes in the criteria and about the need for further research. As envisioned here, the panel would not have the power to force service providers and other stakeholder groups to adopt the criteria or adhere to recommended changes in the existing criteria. However, the authority of the panel would strengthen and support efforts at the State level to implement the panel's recommendations.

What Issues Must Be Addressed by the UPPC of the Future?

With the advisory panel in place, the evaluation of future technology and progress in treatment methods would continue. For the criteria to remain viable, the multidisciplinary approach must be ensured by continued representation of many groups on the panel. Participation by consumers, patient advocates, and an ethicist will add validity and acceptability to the evaluation of new concepts, tools, and technology.

Another important area that must be considered is the need to keep the criteria flexible and amendable. There are dangers in structuring treatment of any kind according to a defined set of criteria. Treatment must remain flexible to meet patients' individual needs and incorporate evolving modalities of care. Clinicians must remain able to exercise judgment in all cases. In addition, if a single approach to care is widely adopted and strictly adhered to as the "correct" approach, treatment innovation may be stifled. The chief value of any criteria set is the added power it gives providers to identify specific patient needs by means of a consistent and detailed assessment process, and to choose a level of care that will specifically address those needs.

Future criteria must be flexible and amendable. Clinicians must remain able to exercise judgment in all cases.

To focus on the criteria themselves and forget their goal—placing patients in appropriate levels of care —is to value the rules above the process and to make rigid what should best remain an open and flexible approach to the complex biopsychosocial problem of AOD abuse and dependence. The principles of the criteria will outlast any single criteria set.

It may be beneficial to regard the implementation of uniform criteria as a major step toward a broader goal of unbundling services to meet individual patient needs. As developments in assessment and treatment technology—guided by future research—open up improved treatment options, the current emphasis on uniform criteria as central to the model of care may lose its urgency. Once the criteria are incorporated into the structure of the treatment system, and patient needs drive the treatment process, the need for criteria (or for central elements of the criteria, such as specific directives about levels of care) may diminish or even disappear.

No matter how comprehensive a uniform set of placement criteria is, individual providers will modify the criteria to fit the needs of the specific patients and populations they serve. Aspects of the criteria that are important in one area with one group of patients may have little relevance to other patient groups. Future developers and implementers of criteria should recognize that the needs of the patients will determine whether elements of the criteria remain viable. Careful research on treatment outcomes should reflect the realities of patient needs and ensure that criteria will evolve to meet changing demands. As in any area of medical treatment, protocols necessarily evolve over time as the understanding of complex conditions increases.

The Role of UPPC in Research

The Importance of Research

The importance of continued research in the AOD abuse treatment field cannot be overemphasized. One result of nationwide healthcare reform efforts has been to reveal that many

people outside the treatment field have little awareness of the efficacy of treatment and are reluctant to include coverage for treatment in a standard benefits package. AOD professionals at all levels have a responsibility to change this perception. Careful research that generates solid data showing the benefits of treatment is the most powerful way to change this perception.

As this TIP was being prepared for publication, results of an important long-term study on the effectiveness of AOD abuse treatment were published (California Department of Alcohol and Drug Programs, 1994). The two-year CALDATA study followed a rigorous probability sample of the nearly 150,000 persons who received AOD abuse treatment in California in 1992. The sample included patients in a spectrum of treatment modalities. The cost of treating the approximately 150,000 participants in 1992 was $209 million, while the benefits received during treatment and in the first year afterwards were worth approximately $1.5 billion.

Thus, for every dollar spent on treatment, $7 in future costs were saved. These savings were largely in relation to reductions in criminal activity and in the number of hospitalizations for health problems. For a smaller sample followed through the second year, results have indicated that projected cumulative lifetime benefits of treatment will be substantially higher than the shorter-term benefits.

The study found that, from before treatment to one year after treatment, criminal activity declined by two-thirds and hospitalizations by one-third. Declines of about two-fifths also occurred in the use of alcohol and other drugs from before to after treatment. Treatment for major stimulant drugs (crack cocaine, powdered cocaine, and methamphetamine), which were all in widespread use, was found to be just as effective as treatment for alcohol problems, and somewhat more effective than treatment for heroin problems. No differences in treatment effectiveness were found by gender, age, or ethnic group.

Future Research

In 1990, an Institute of Medicine report on treating alcohol abuse asked the question, "Which kinds of individuals, with what kinds of alcohol problems, are likely to respond to what kinds of treatments by achieving what kinds of goals when delivered by which kinds of practitioners?" (Institute of Medicine, 1990). Future research must investigate questions at this level of detail, taking into account in systematic ways the myriad variables that contribute to treatment success.

- Long-term research is needed to evaluate treatment outcomes and to identify areas where specialized research is needed.
- More attention must be given to positive outcomes other than complete abstinence. These include curtailed criminal behavior, improved employability, achievement of stable housing, and reduction of detoxification episodes and hospital admissions.
- UPPC can be refined if research addresses the aspects of a patient's history and symptoms that have the most significance for choosing the appropriate level of care.
- Automated systems designed for the assessment, placement, and treatment of AOD patients should be studied. It may be possible to use "expert systems" to assist in making placement decisions.
- Valid and reliable scales are needed that will help objectify the measurement of severity for each aspect of a multidimensional assessment.

- Experimental research must be done to determine how an assessment dimension affects the placement decision. For example, how do subgroups of clients vary on such dimensions as acceptance or resistance to treatment and relapse potential?
- Particularly important research areas for the development of UPPC are those that involve the matching of clients to specific services and modalities based on assessment data.

Current Efforts

Important work is already being done to address these needs. For example, one ongoing naturalistic outcome study found that approximately 90 percent of people whose AOD treatment continued in some form over the course of 1 year remained abstinent for that year (Hoffmann and Miller, 1992). This finding provides strong support for the concept of providing treatment of sufficient intensity and duration, which is a central principle underlying the concept of UPPC. A study of relapse of AOD patients found that those who returned to treatment over a 2-year period had a greater number of diagnoses at first admission than patients who did not return to treatment over that time frame. (Renz et al., in preparation).

McLellan and others have conducted small-scale studies showing that matching patients to programs or services that best meet their needs will improve treatment outcomes. (McLellan et al., 1983; 1993). McLellan and Alterman (1991) have stressed the need for much larger efforts involving diverse populations and services to attain the goals of improving treatment outcomes and determining cost effectiveness.

The National Institute on Drug Abuse has provided a grant to the National Center for Addictions Treatment Criteria at Harvard Medical School to study placement criteria. Information gained through the funded studies will aid in the development of the next generation of criteria. Experience gained in conducting the studies will also provide guidance to the development of an evaluation plan for UPPC.

The Role of UPPC in Research on Assessment, Treatment, and Outcome

Matching patients to treatment based on their needs, with the flexibility to adjust services for individuals, has long been an important goal of the AOD abuse treatment system. The widespread acceptance of UPPC will bring the field much closer to achieving this goal. Having UPPC in place will work to ensure that treatment continues to be driven by patient needs rather than solely by fiscal considerations, ideology, or other factors imposed from outside the treatment system.

One of the most important aspects of uniform criteria is the consistency that their application can bring to the AOD assessment and treatment process. A viable set of uniform criteria will describe all the areas to examine in a comprehensive biopsychosocial assessment of patients at all entry points to the treatment system. The criteria should also describe specific levels of care, treatment modalities, and components that will effectively address patients' needs uncovered in the assessment. The criteria must address a wide spectrum of needs—from acute care needs, such as the need for detoxification, to needs for support services, such as childcare and transportation, which often make the difference in successful access to treatment.

Feedback Loops

In effect, the criteria and the structure they provide to the placement and treatment process create the possibility for establishing several ongoing feedback loops, allowing researchers to ask precise questions and design appropriate studies. Careful research at every stage is essential to the interaction among UPPC and assessment, treatment, and outcome. Figure 6-1 illustrates this interactive process and provides a way of visualizing the role of research at various points in the process. As discussed below, most research will focus on the effectiveness of treatment based on UPPC—that is, the focus will be on the "Treatment Outcomes" box in Figure 6-1. However, there are several other areas where careful research can improve treatment and cost effectiveness.

Assessment

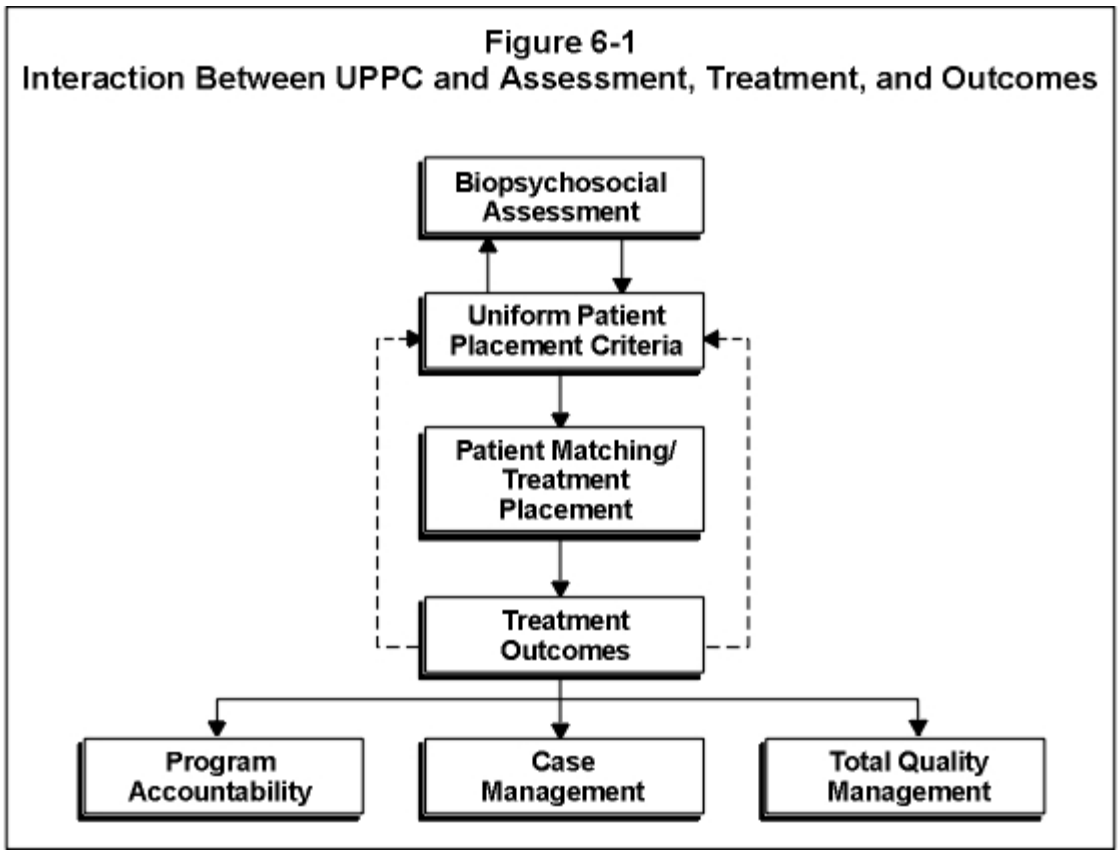
For example, researchers may choose to focus on evaluating the first step in the process, which is the relationship between UPPC and the biopsychosocial assessment. Research at this point might examine the extent to which patient assessments in a large agency or several agencies actually gather the assessment data specified in the criteria. Differences in placement between subgroups of patients may lead to further research about new areas to assess, which may in turn lead to suggestions for improving the assessment process. In some agencies, research at this level might reveal that certain dimensions of need are not being assessed because no services exist to address those needs. As discussed below, important data about patient populations may be lost if assessments are not conducted according to the criteria.

Resource Management

Research at the next point in the process—that is, research focusing on the "Patient Matching/Treatment Placement" box in Figure 6-1 —will provide invaluable data for needs assessment and resource management within agencies and across systems. Even though many AOD treatment agencies and systems will conduct thorough biopsychosocial assessments, they may not have the ability to place patients in levels of care or provide services specified by the criteria because of a lack of resources or other factors. Researchers can capture aggregate data that will show, for example, that a large subgroup of patients with specific needs is not receiving appropriate care. Resources may then be directed to developing these services. Systems can be creatively linked to pool scarce resources, such as medical care, childcare, and transportation services.

Outcome Research and Quality Improvement

One way that UPPC will greatly improve the quality of treatment outcomes research is by improving the capability to describe research samples. (Another TIP currently in development in this series is *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*.) In effect, structuring the AOD assessment based on UPPC will result in categorizing patients according to illness severity and a wide spectrum of needs.



Researchers will be able to focus on and compare specific samples and subsamples of patients with a similar severity of illness and with specific needs profiles. It is universally agreed that making comparisons between more carefully described samples leads to more valid results.

For example, a group of patients with a particular needs profile, such as single adolescent mothers with a defined severity of illness and specific assessed needs for certain social supports, will be assigned to a particular level of care with a core set of treatment modalities. Researchers can then evaluate differences in their treatment outcomes, which may identify other factors that need to be addressed. For example, it may be found that differences in interpersonal functioning may greatly affect outcome. One subgroup of adolescent mothers with significant deficits in interpersonal skills may have notably poorer treatment outcomes (as measured, for example, by a greater number of or more severe relapses) than a comparable subgroup with good interpersonal skills. AOD treatment services that address these deficits may be found to improve treatment outcomes as well as cost effectiveness of services (as measured by fewer inpatient episodes or reduced need for costly have found themselves withintensive services).

These research findings can be fed back into the process of reviewing criteria (dotted lines in Figure 6-1). New research may address the question of interpersonal functioning and its importance in the initial biopsychosocial assessment. Research may subsequently lead to the specific inclusion of this dimension in the UPPC. Many programs and providers will not have to wait for the published results of empirical research to perceive that certain placements and

services for certain subgroups of patients are not as effective as expected, and they will develop new services to meet those needs.

The role of UPPC in quality improvement and program accountability is clear. The advantages that the criteria give to researchers, they give also to programs and systems. This results in more effective outcome monitoring and program and service evaluation. In effect, implementation of UPPC can help establish the self-correcting system that is the foundation for total quality management (TQM) (Walton, 1990). TQM is a focused management philosophy for providing the leadership, training, and motivation to continuously improve an organization's operations. For a more detailed description of TQM in an AOD treatment setting, see the TIP in this series, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.*

The Role of UPPC in Healthcare Reform

At the time of this TIP's development, legislators and policymakers were engaged in the process of reforming the healthcare delivery system. The goals of uniform patient placement criteria and those of healthcare reform are the same: improved quality of care, greater access to care, and reduced costs. Both healthcare reform and UPPC place a major emphasis on outcome evaluation. It is essential that both groups—those working toward reform and those working toward consensus building around UPPC—recognize that their goals are shared, or they will be working at cross-purposes.

The benefits sets proposed as a part of healthcare reform have included standard limits on AOD treatment. These limits are specified as a fixed number of days or hours of service or number of treatment admissions over a given period of time. UPPC could lay the groundwork for legislators to address AOD treatment in the same manner as other health problems, rather than impose arbitrary cost or time limitations.

A national benefits package for AOD treatment that does not recognize the provisions for levels of care and treatment components laid out in the criteria will render the criteria useless. It is important that those who develop UPPC take into account the current realities of the healthcare environment. There is a need for close collaboration between UPPC and healthcare reform efforts. Criteria should help define the parameters of reimbursable services.

However, the reality is that these groups, which are united in principle, have had very little interaction. The proposed benefits packages that have included AOD treatment and that have been discussed in the national arena have not mentioned UPPC. Early versions of healthcare reform plans focused on service units and on limiting coverage according to units used. Defining care according to limited amounts is not within the spirit of UPPC—or even within the recognized realities of treatment outcomes. For example, in one study, a quarter of those who had successfully completed treatment (defined as 1 year of sobriety) had exceeded the limit on units of treatment, according to one of the healthcare reform proposals (NSI Congressional Briefing, 1994). Studies have shown that a minimum of 3 to 6 months of continuing care is critical to recovery (Hoffmann and Miller, 1992). A benefits package that limits care short of

critical thresholds does not recognize the importance of a continuum of care and will not serve the needs of patients. Those who are currently involved in efforts to build consensus around UPPC have not created a strong enough constituency to have political consequence at the level that healthcare reform is now being addressed.

The advantage of using UPPC as unifying treatment structure is that the criteria can work within any healthcare reform plan. For example, if research finds that 35 percent of those who require a certain level of care are not receiving it, then the data can be used to change funding mechanisms and make reform efforts more responsive to clinical realities.

If criteria are part of the reformed healthcare delivery system, they will work toward ensuring equal access to treatment. Based on the criteria, patients with similar needs will be placed in the same level of care and will receive similar services. They will work toward making some services available to most people—a significant step in ensuring equal access to care.

Rationing

The rationing of treatment services is not widely discussed, but it does occur. Many discussions about the topic portray managed care organizations as the culprit because they sometimes do not authorize the level of care, frequency, or length of care that is requested. In fact, healthcare services are rationed in other ways that have similar effects on those needing AOD abuse treatment.

For example, in the AOD abuse treatment field, rationing occurs in the sense that those who have private insurance or financial resources to pay for their care generally experience fewer impediments to receiving treatment than those who are uninsured or underinsured. Those who have Federal Medical Assistance or Medicare traditionally have had access to care, although primarily in the public system. Those lacking insurance or sufficient income have depended primarily on the public system to provide their AOD treatment services. Those with some income but without insurance (either because they have no policy or because the policy does not cover AOD treatment services) have found themselves with little access to care in either the private or the public system. When the public system is overloaded, another kind of rationing occurs because the number of treatment slots does not meet the demand for treatment. In fact, most insurance of any description has limitations on the type of service, the number of visits, or the amount of payment it will provide for AOD abuse treatment.

Thus, rationing occurs among both managed care organizations and AOD treatment programs and providers. Public policy also plays a role when it establishes eligibility criteria for publicly funded programs and identifies target populations for service priority. While such decisions may be necessary because of the scarcity and lack of access to sufficient treatment resources for the affected populations, the end result is that care is rationed.

UPPC cannot solve the dilemmas posed by these circumstances. However, when UPPC are linked with healthcare reform, with the overall needs of individual clients, and with responsive public policy, they have the potential to provide a reasonable basis for decisionmaking about the placement and range of AOD treatment services necessary for an individual.

Summary

UPPC will help to shape the direction of the AOD treatment field on a national level. Therefore, it is important to reach reasonable consensus within the field on the strengths and weaknesses of existing criteria sets in order to move forward. More empirical evidence is needed to demonstrate that uniform criteria can accomplish expected goals. The panel recommends the formation of a national advisory panel while research is continuing. The panel could guide the consensus-building and implementation process and play a continuing role in the refinement of UPPC.

The use of UPPC will greatly increase the ability of investigators to design and carry out the types of careful studies that are needed to demonstrate the effectiveness of AOD abuse treatment.

Chapter 7—Ethical and Legal Issues

Ethics is concerned with the rightness of human conduct—with the question of what should be done in a particular situation. On a more personal level, ethics is also concerned about what sort of person "I" should be. This is sometimes referred to as virtue ethics. Ethical dilemmas arise when two potentially competing courses of action can each be morally justified or considered to be "right." No area of patient care is devoid of potential ethical questions. Physicians and other care providers have duties to the patient, to the profession in which they practice, to the organization or agency in which they practice, and to the society at large.

Ideally, ethics and laws should reinforce one another, and the law should serve as the mechanism by which ethical values and principles are put into practice. Some laws, however, are blatantly immoral, such as those that allowed slavery. One cannot rely solely on law to provide guidance in the care of patients or clients. The law requires that certain rules be followed and imposes penalties for failure to do so. The law is a rigid system; as such, it is somewhat impersonal. Ethics, on the other hand, is not standardized or impersonal. Ethical judgments are based on the nature of the relationships between persons and on the primary value that individuals should strive to achieve a "good life." In the areas of professional practice, penalties are generally determined by one's profession. Codes of ethics are promulgated by the various professional organizations to guide a professional's behavior.

Ethical Principles and AODPrinciples and AOD Abuse Treatment

With respect to patients, several ethical principles based upon duties between individuals emerge. These principles include:

- *Beneficence*—the duty to promote good and prevent harm to patients
- *Nonmaleficence*—the duty to do no harm to patients
- *Respect for a patient's autonomy*—the duty to recognize the patients' right to make their own decisions
- *Justice*—the duty to treat individuals fairly (provide access to an adequate level of healthcare).

From these principles arise rules about informed consent, confidentiality, truth telling, and disclosure.

Ethical issues that must be addressed in providing alcohol and other drug (AOD) abuse treatment are often more complex than those that arise in the everyday practice of medicine. Many of the ethical dilemmas that characterize AOD treatment concern the need to protect patients' privacy. Because of the stigma that continues to be associated with AOD disorders, maintaining confidentiality is an important aspect of engaging patients in treatment. Two Federal laws and a set of regulations guarantee the strict confidentiality of information about all persons receiving

AOD abuse assessment, referral, and treatment services. Many States also have laws and regulations governing the confidentiality of patient records. Legal issues surrounding confidentiality and patient consent are discussed more fully in several other TIPs, including *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* and *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*.

Thus, in the case of confidentiality, law and ethics work hand in hand. The law reinforces the ethical obligation to respect a person's autonomy by supporting patients' rights to control information about themselves.

AOD treatment providers have an ethical obligation to protect patients' privacy and must ensure that communications with persons or agencies about patients in their care adhere to laws, regulations, and ethical standards. However, third-party payers may request access to a patient's entire treatment record. As discussed below in the section on legal issues, implementation of uniform patient placement criteria (UPPC) may help resolve ethical dilemmas about patient confidentiality and provide greater clarity to the legal term "medical necessity."

Patient Autonomy and Informed Decisionmaking

Other ethical dilemmas arise in the area of patient autonomy—that is, the individual's right to make decisions regarding treatment. In recent years, patient autonomy has become a central tenet in medical ethics, and debate has arisen over such issues as the importance of involving patients in all treatment decisions—including AOD treatment decisions—and their right to be informed about and to refuse treatment in certain situations.

Making treatment decisions based on UPPC may present dilemmas involving patient autonomy if the decisionmaking process relies too heavily on the criteria alone and does not take patient choice into account. For example, results of the biopsychosocial assessment may indicate unequivocally that a certain patient should be placed in a certain level of care and receive specific services. However, the patient may prefer to obtain treatment at a less intensive level of care—a level at which treatment outcomes for that patient are far less likely to be successful.

AOD treatment providers have always been faced with such dilemmas, even outside the framework of patient placement criteria. However, as UPPC are further refined by research, having them in place will provide strong supportive documentation to the treatment provider's clinical judgment. In addition, managed care organizations and third-party payers may tie reimbursement to placements dictated by the criteria. In this way, UPPC may work toward limiting patient autonomy. Providers should ensure that the patient's voice is heard in the assessment process and throughout treatment planning. Treatment providers must be able to make placements based on individual treatment needs.

Clinicians who conduct the biopsychosocial assessment will be placed in an ethical dilemma: Should this patient be forced into a specific treatment setting with better success rates against her wishes? If so, what is the justification for overriding this patient's treatment requests? Do her objections to a specific treatment alter the probability of its success? How should the provider

weigh the obligation to benefit this patient against the provider's duty to respect the patient's right to self-determine?

As we obtain additional outcomes data, this dilemma may be lessened. Knowledge of the anticipated risks and benefits of treatment alternatives often leads to better communication and agreement between clinician and client.

Legal Issues and AOD Abuse Treatment

The Changing Healthcare Environment

Patient placement criteria developed by States and private and professional organizations have arisen in a healthcare environment undergoing rapid changes and pressured to change further. As discussed in Chapter 6, efforts to establish UPPC for alcohol and other drug abuse treatment share many of the goals of healthcare reform efforts: more equitable access to healthcare, better quality care, and a more efficient system of healthcare delivery that reduces rising costs.

The introduction of managed care and other efforts to meet the goals of healthcare reform have led in many instances to disputes between treatment providers and third-party payers about reimbursement, admission, and continued stay and discharge criteria. In many of the disputes that characterize today's treatment environment, third parties often request the patient's entire AOD treatment record, which may contain information that the provider does not consider relevant to placement and treatment decisions. A classic ethical dilemma arises. This dilemma has legal aspects because of Federal and State laws protecting patient confidentiality. The AOD treatment provider may be forced to choose between equally competing obligations. The clinician is obligated to protect the patient's confidentiality. However, the clinician is also obliged to provide information to third-party payers in order to receive reimbursement and ensure continuation of treatment.

Many disputes center on treatment services that payers do not believe are medically necessary. One of the most compelling reasons for widespread adoption of UPPC is the important role they will play in reducing disputes between payers and providers and giving providers and payers a common framework for determining which information is relevant to placement and treatment decisions. Providers are cautioned to err on the side of confidentiality in those situations in which there is no clear answer to the dilemma. The release of AOD treatment records is like Pandora's box—once opened it is difficult, if not impossible, to return to the original state.

Medical Necessity

Almost all plans for third-party health insurance limit coverage to services and supplies that are "medically necessary." While plans may define the term differently, the intent of such provisions is to exclude from coverage unnecessary treatment services, equipment, and supplies. Most plans' definition of medically necessary services include, at a minimum, the following elements:

- The service must be ordered by a professional whose license qualifies him or her to diagnose and deliver treatment.
- It must be of the proper quantity, frequency, and duration for the condition being treated.
- It must not be experimental or investigative.

Failure to satisfy the second element is generally the issue in disputes between AOD treatment providers and third-party payers. The argument often centers on whether the course of treatment is consistent with generally recognized medical standards. The ultimate resolution of many such disputes is in a court of law. The courts take into consideration the contractual terms of the plan or policy, as well as the differing opinions or testimony of medical experts. The outcomes of disputes that are settled prior to litigation are, of course, influenced by how the courts have settled similar cases in the past.

Uniform patient placement criteria, if they are developed according to the consensus-building process outlined in this document, will represent the opinions of AOD abuse treatment providers from many disciplines. The criteria may be viewed by courts as reflecting generally accepted medical practice, especially as the criteria become widespread. In situations in which an insurer or payer has applied its own criteria or standard of medical practice rather than UPPC, the issue in court will in all probability focus on whether the insurer's criteria are significantly different from those of the medical and AOD treatment community.

As UPPC gain acceptance, the standard they provide will help resolve disputes before litigation is necessary.

Payers have been held liable when they have applied standards of medical necessity that are significantly different from those of accepted medical practice. In 1989, a California court of appeals in *Hughes v. Blue Cross of Northern California* (263 Cal Reptr. 850 Cal. App. 1 Dist. 1989) had an opportunity to review an insurer's standard of medical necessity in the denial of psychiatric benefits for several episodes of inpatient confinement of a chronically suicidal patient. The patient, who was twice released from inpatient care to outpatient programs, required a series of intensive inpatient admissions and was finally transferred to an institution for long-term care. Blue Cross had denied portions of the inpatient care on the basis that a lower level of care (i.e., outpatient) was appropriate.

The court disagreed and upheld a jury award of compensatory and punitive damages. In reviewing the policy's limitation of benefits to medically necessary care, the court stated:

If the insurer employs a standard of medical necessity significantly at variance with the medical standards of the community, the insured will accept the advice of his treating physician at a risk of incurring liability not likely foreseen at the time of entering the insurance contract. Such a restricted definition of medical necessity, frustrating the justified expectation of the insured, is consistent with the liberal construction of the policy language required by the duty of good faith. . . . Good faith demands a construction of medical necessity consistent with community medical standards that will minimize the patient's uncertainty of coverage in accepting his physician's recommended treatment.

The *Hughes* decision reaffirms the view taken by many courts that "medical necessity" or similar policy language is an objective standard to be applied by the trier of fact, not a delegation of power to the treating physician. When an insurer employs an unreasonable standard of medical necessity, it acts at its own peril.

Whether UPPC will be recognized in future court decisions as generally accepted standards that reflect accepted practice as defined by the AOD treatment community will depend largely on the extent to which the criteria are accepted and adopted by providers who make AOD treatment decisions. If the field does not act to build consensus around placement criteria and to implement UPPC, then such criteria will probably be applied from outside.

Confidentiality and Patient Records

Gone are the days when a course of treatment was considered medically necessary simply because it was ordered by a physician. In terms of patient placement within levels of care defined by UPPC, the decision of the treatment team will be reviewed by the insurer or managed care company and possibly by a judge and/or jury. For this reason, it cannot be emphasized strongly enough that all placement decisions should be well documented at every stage.

Patient records are maintained primarily to provide complete information regarding the care and treatment of patients. The primary purposes of the patient record are to:

- Provide a planning tool for patient care
- Record the course of treatment and the changes in a patient's condition
- Provide information necessary for third-party billing.

A complete and accurate clinical record is as important for reimbursement purposes as it is for treatment purposes. Third-party reviewers, whether prospective or retrospective, do not ordinarily have the opportunity to examine the patient. They obtain information from first-hand evaluations recorded in the patient record. As their decisions are often based exclusively on the patient records supplied by the treatment provider, the records must be well maintained. If not, even a patient clearly needing treatment may have problems when insurance claims are submitted for payment.

With respect to documenting and supporting AOD treatment decisions based on UPPC, the following recommendations are made:

- The patient record is a historical document that records how and why treatment decisions are made. Every provider who makes an entry in a patient's record should make that entry with the understanding that it will be reviewed and scrutinized by the insurer or other third-party payer.
- All entries should be neat and legible, clear, and concise—but complete and meaningful to each patient's course of treatment. Providers in facilities that have adopted patient placement criteria must learn to speak the language of the criteria. The evaluation forms, progress notes, and other components of the patient record must relate specifically to the criteria that use the same terminology.

- The patient record should include specific illustrations to demonstrate that a patient has been assessed on a specific dimension outlined in the criteria and that ongoing attention is focused on that area. For example, if one dimension outlined in the criteria relates to treatment acceptance/resistance, it is not enough to simply state in the record that a patient is resistant to treatment. Such a statement provides no evidentiary support. Rather, specific examples of observed patient behavior, statements, or history that clearly indicate treatment resistance should be included.
- Before making an entry, providers should review previous entries. A patient record has several authors. Care should be taken not to ignore the entries made by others. Conflicting or inconsistent entries damage the credibility of the entire record.
- While a "defensive" or "patient welfare" approach to recordkeeping is prudent, the integrity of patient records should not be compromised by deliberate misstatements or alterations. Such conduct has grave ethical aspects and will surely backfire if discovered by a payer. Such conduct also has serious legal implications for the provider.

In sum, when the patient record is professional, accurate, and complete, it is the provider's, client's, and attorney's ally in the recovery of a claim denied for lack of medical necessity. While it is possible to submit to payers and introduce into evidence in a legal proceeding information and records developed after the fact in support of a treatment decision, such support is rarely given the same weight and credibility as medical records developed and maintained during the actual treatment period.

Disclosing Patient Information to Third Parties

Managed care is likely to be the basis for reform of the healthcare delivery system, and many patients currently receive treatment under some form of managed care. Increasingly, managed care agencies and other third parties are scrutinizing treatment decisions, such as decisions to transfer patients to a more intensive and costly level of care. In many cases, they may request a patient's entire record. Deciding what information is material to a treatment decision and should be released to a payer, or whether to release requested information, can present a dilemma. Although patients generally sign forms giving broad consent to providers to release information to insurers, the laws and regulations regarding confidentiality require that providers carefully consider such requests for information.

Having uniform patient placement criteria in place can help providers make decisions about disclosing information to third parties. For example, a decision to place a certain patient at a certain level of care will usually be based on specific guidelines laid out in the placement criteria. If a third party requests to see a patient's entire record, providers may be able to make a case for limiting the release of information to only those records that relate to UPPC guidelines. However, if the third party ties reimbursement to strict compliance with its requests for information, a serious ethical dilemma results. Nevertheless, compliance with requests for information by third parties should be made on a case-by-case basis. Only that information that is considered material to the treatment decision under discussion should be disclosed.

Summary

In summary, whether a particular level of care is medically necessary for the treatment of AOD use disorders has historically been a controversial issue between providers and payers. The future implementation of UPPC offers a much-needed solution to this troubled area. The widespread acceptance of UPPC may contribute to the demise of criteria driven primarily by economic rather than medical and treatment concerns. It is hoped that UPPC will provide a level playing field for all players.

Appendix A—References

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Appendix B—Resource List

Several types of materials may be useful to programs or systems seeking to create or adapt patient placement criteria (PPC). Information gained from careful assessment is essential for making appropriate placement decisions. This appendix describes instruments for assessing the severity of alcohol and other drug (AOD) use and related problems, the potential for withdrawal symptoms, and attitudes toward treatment. The Level of Care Index (LOCI) and Recovery Attitude and Treatment Evaluator (RAATE) instruments were designed to be compatible with the PPC developed by the American Society of Addiction Medicine (ASAM). The authors of these instruments were members of the consensus panel that developed this Treatment Improvement Protocol (TIP). Two software packages to aid clinical management and treatment planning are also described. Dr. Paul Earley, who developed one of the software packages, is an *ex officio* member of ASAM's board of directors.

For readers who wish to examine existing criteria in more detail, the next section lists information about how to obtain criteria sets from various States and private organizations. The final section of the appendix presents information on ordering a variety of materials on managed care to help programs and systems prepare for healthcare reform.

Alcohol and Other Drug Use and Psychosocial Assessment Instruments

A comprehensive assessment of each patient entering treatment is needed and should include the following:

- History of alcohol and other drug abuse
- Medical history
- Mental health history
- Psychosocial history.

A number of assessment instruments are widely used to collect information that is helpful in diagnosis and treatment planning. The instruments that are especially pertinent to the concepts discussed in this TIP are listed below. Other instruments are also available that illustrate the ways in which individual treatment programs have developed or tailored assessment tools to meet the particular needs of their patient populations.

The listing of a particular assessment instrument in no way implies an endorsement of that instrument, nor is the following list intended to be inclusive or representative of all assessment instruments that may be used by treatment programs. The instruments included here are used or recommended by some treatment providers.

A collection of sample assessment instruments is available as a package from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD

20847-2345; (800) 729-6686; (301) 468-2600; TDD (for hearing impaired): (800) 487-4889; fax: (301) 468-6433.

Addiction Severity Index (ASI)

The ASI, now in its fifth edition, is the most widely used standardized assessment tool in the field. It is a highly structured clinical interview consisting of 161 items. The ASI is designed for a trained technician to rate the severity of problems in six areas: medical, psychological, legal, family and social, employment and support, and use of alcohol and other drugs.

Source: McLellan, A.T.; Kushner, H., and Metzger, D. The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9(3):199-213, 1992. The National Institute on Drug Abuse (NIDA) has developed a technology transfer package, which includes the ASI, two 60-minute training videotapes on the use of the ASI, a training facilitator's manual, and a program administrator's handbook. The package is not available directly from NIDA, but information on obtaining it is available through NIDA's toll-free number.

Ordering Information: Available from NCADI; (800) 729-6686; fax: (301) 468-6433. Also, the clinical version of the fifth edition of the ASI is reproduced in the TIP *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, which is also available from NCADI.

Cost: None for some materials

Clinical Institute Withdrawal Assessment for Alcohol Scale--Revised (CIWA-Ar)

The CIWA-Ar aids in measuring acute intoxication and/or withdrawal potential. With the use of CIWA-Ar, 15 symptoms of withdrawal can be measured in 3 to 5 minutes. A 60-minute videotape, "The Alcohol Withdrawal Syndrome," has been developed to train clinical staff in use of the CIWA-A (longer version of revised CIWA).

Source: Sullivan, J., Sykora, K., Schneiderman, J., Naranjo, C., and Sellers, F. Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol Scale. *British Journal of Addiction* 84:1353-1357, 1989.

Ordering Information: Available from the Addiction Research Foundation, Marketing Department, 33 Russell St., Toronto, Ontario, Canada M5S-2S1; (800) 661-1111.

Cost: Instrument: none; videotape: $250, plus $25 shipping

Level of Care Index (LOCI)

The LOCI tools are clinical checklists that aid in decisionmaking about the appropriate level of care for patients with substance use disorders. Separate tools address decisions about: admission, continued stay, and discharge/transfer. The indexes are designed to be compatible with the

ASAM patient placement criteria and summarize dimensions and decision points contained in those criteria. There are separate indexes for adults and adolescents.

Source: Mee-Lee, D., and Hoffmann, N.G. *LOCI--Level of Care Index: A Concise Summary of ASAM Criteria's Factors to Document for Placement, Continued Stay, and Discharge.* St. Paul, Minnesota: New Standards, 1992.

Ordering Information: Available from New Standards, Inc., 1080 Montreal Ave., Suite 300, St. Paul, MN 55116; (612) 690-1002; fax: (612) 690-1303. Forms are available for the separate assessment areas (admission, continued stay, and discharge/transfer) and are sold separately in packs of 25.

Cost: $24.50 for a pack of 25

Recovery Attitude and Treatment Evaluator (RAATE)

The RAATE is an instrument used for determining severity of addiction based on assessment of five dimensions. These include: resistance to treatment, resistance to continuing care, acuity of biomedical problems, acuity of psychiatric and psychological problems, and social/family environmental status. The RAATE Clinical Evaluation is completed by the clinician, and scores in each dimension are keyed to the four levels of care described in the ASAM criteria. The RAATE Questionnaire I is a 94-item true-false instrument completed by the patient, which elicits information about the five dimensions.

Source: Mee-Lee, D. An instrument for treatment progress and matching: the Recovery Attitude and Treatment Evaluator (RAATE). *Journal of Substance Abuse Treatment* 5:183-186, 1988.

Ordering information: Available from New Standards, Inc., 1080 Montreal Ave., Suite 300, St. Paul, MN 55116; (612) 690-1002; fax: (612) 690-1303. An introductory kit is available that includes a manual, 25 Clinical Evaluation (CE) forms, 25 Questionnaire I (QI) forms, and a scoring template. PC disks can be prepared upon request.

Cost: Introductory kit: $125; Extra CE and QI forms: $56.25 for pack of 25 forms; PC disk, $4.50 per interview

Problem Oriented Screening Instrument for Teenagers (POSIT)

The POSIT is a self-administered 139-item screening questionnaire that was developed by NIDA. It was designed as part of a more extensive system for adolescents, the Adolescent Assessment/Referral System (AARS). It measures problem severity in 10 domains that are often related to substance abuse and that are amenable to treatment intervention. Domains include substance abuse, physical health, mental health, family relations, peer relations, educational status, vocational status, social skills, leisure/recreation, and aggressive behavior.

Source: Radhert, E.R. The Problem Oriented Screening Instrument for Teenagers, in Radhert, E.R., ed., *The Adolescent Assessment/Referral System Manual*. DHHS pub. (ADM)91-1735. Washington, D.C.: Government Printing Office, 1991.

Ordering information: Available from NCADI; (800) 729-6686; TDD (for hearing impaired), (800) 487-4889; fax: (301) 468-6433. Request the *Adolescent Assessment/Referral System Manual*.

Cost: None

Software

Computerized Placement System

This patient placement management software allows users to structure the system according to their own criteria and rules. Based on the criteria, the system generates a placement form to be filled out by the clinician during patient assessment. When these data are entered, the system produces a placement matrix and a continued stay review form, with a due date based on placement rules, for the clinician's use. Additional continued stay forms for each patient are generated as needed. To facilitate management of large numbers of patients, the system generates a list of forms and reports due each day, as well as summary data of several kinds. A treatment planning module is being developed.

Ordering information: Contact Michael Ruppert, MRM Enterprises, P.O. Box 1153, Helena, MT 59624; fax only: (406) 443-5490.

Cost: $2 per patient unit; discounts for large orders

TxPlan

TxPlan is a professionally developed, highly customizable, clinical management software system. It tracks patients from intake and facilitates the writing of individualized treatment plans, progress notes, and discharge summaries. Problem databases can be created for any patient population or level of care. TxPlan's chemical dependency database of approximately 100 problems is organized according to the six dimensions of the ASAM criteria. Clinicians can identify a patient's problems in each dimension and then have a choice of up to 15 objectives and interventions for each problem.

Ordering information: Contact Judith K. Earley, Ph.D., President, Earley Corp., 407 Ponce De Leon Ave., Decatur, GA 30030; (404) 370-1212; fax: (404) 378-0346.

Cost: Single-user license: $1,295; network license: $2,590 (up to three users) to $10,590 (unlimited users); customization programming: $80/hour; onsite installation and training: $975/day plus expenses.

Criteria Sets

Patient placement criteria developed by the American Society of Addiction Medicine and by several States and private organizations can be used as models in creating, adapting, or amending patient placement criteria. Several criteria sets are described below, with ordering information.

American Society of Addiction Medicine

Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders

These criteria offer clinical guidelines for matching patients with substance use disorders to appropriate levels of care. Four levels of care are described: outpatient treatment, intensive outpatient/partial hospitalization, medically monitored intensive inpatient treatment, and medically managed intensive inpatient treatment.

Ordering information: Available from the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; (301) 656-3920.

Cost: ASAM members: $45; nonmembers, $65

State Criteria

Iowa

Iowa Client/Patient Placement Criteria: Treatment of Psychoactive Substance Use Disorders (1991)

These criteria were developed by the Chemical Dependency Treatment Programs of Iowa and the Iowa Substance Abuse Program Directors Association. Seven levels of care are described: continuing care, halfway house, extended outpatient treatment, intensive outpatient treatment, primary/extended residential treatment, medically monitored inpatient treatment, and medically managed inpatient treatment.

Ordering information: Contact Janet Zwick, Director, Division of Substance Abuse, Iowa Department of Public Health, Lucas State Office Building, Third Floor, Des Moines, IA 50319; (515) 281-3641; fax: (515) 281-4535.

Cost: No cost at this time

Massachusetts

Substance Abuse Outpatient Counseling; Detoxification Services; Youth Residential Criteria; Methadone Treatment Criteria (draft)

The Bureau of Substance Abuse Services has collaborated with substance abuse treatment providers throughout the State to develop standardized admission, discharge, and continuing care criteria for several substance abuse treatment modalities, which are available in a single document. The criteria are modeled on the ASAM patient placement criteria but were modified and supplemented to better represent needs of public-sector clients and available services. The State is now developing criteria for residential recovery services.

Ordering information: Contact Shelly Steenrod, M.S.W., L.I.C.S.W., Regional Manager, Massachusetts Bureau of Substance Abuse Services, 150 Tremont Street, Boston, MA 02111; (617) 727-7985.

Cost: No cost at this time

Minnesota

Rule 25: Assessment and Placement for Public Assistance Recipients

The State developed these criteria in collaboration with treatment providers and county social service agencies. They were implemented in 1988 with a consolidated funding system. Rule 25 is more concise and user friendly than the ASAM criteria but does not describe as comprehensive an assessment or contain continued stay criteria.

Ordering information: Contact Lee Gartner, Planner Principal, Chemical Dependency Program Division, Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3823; (612) 296-3991; fax: (612) 297-1862.

Cost: No cost at this time

Montana

Administrative Rules of Montana, Chapter 3, Chemical Dependency Rules

The Montana rules for patient placement are conceptually based on the ASAM criteria. Three levels were added to ASAM's four levels to allow more flexibility within the medical levels of care.

Ordering information: Contact Norma Jean Boles, R.N., Manager, Montana Department of Corrections and Human Services, 1539 11th Ave., Helena, MT 59620; (406) 444-4931; fax: (406) 444-4920.

Cost: None

Washington State

Criteria for the Admission and Transfer/Discharge of Adult Chemical Dependency Patients in Washington State

These criteria were developed by chemical dependency assessment and treatment professionals, in consultation with representatives of the insurance industry and their agents, to address problems created by the impact of managed care practices on the chemical dependency treatment system and patients. They were modeled on the ASAM criteria, and modified to better reflect needs of the public sector and of small outpatient treatment providers.

Ordering information: Contact Henry L. Govert, M.A., Program Manager, Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services; (206) 438-8092.

Cost: None

Private Criteria

Green Spring Health Services, Inc.

Green Spring Utilization Review Criteria

These criteria, developed to guide patient placement in the least intensive, least restrictive level of care, describe six levels of substance abuse treatment, and include guidelines for admission, continued stay, and discharge.

Ordering information: Contact Jonathan Book, M.D., Senior Vice President, Chief Medical Officer, Green Spring Health Services, Inc., 5565 Sterrett Pl., Suite 500, Columbia, MD 21044; (410) 964-6092.

Cost: None

Health Management Strategies International, Inc.

Mental Health Review Criteria

These psychiatric and substance use criteria constitute the entire spectrum of utilization management screening guidelines used by Health Management Strategies International, Inc.

Ordering information: Write Health Management Strategies International, Inc., 1725 Duke St., Attention: Criteria Request, Suite 300, Alexandria, VA 22314.

Cost: $10

MCC Behavioral Care

Level of Care Guidelines for Mental Health; and *Substance Abuse Preferred Practices Guide*

These two documents provide information to decisionmakers about appropriate mental health and substance abuse treatment. The level of care guidelines help define and promote an

appropriate and flexible approach to the treatment continuum. The practices guide is used by case managers to review proposed levels of mental health and substance abuse placement.

Ordering information: Contact John Bartlett, M.D., Vice President, Corporate Medical Director, MCC Behavioral Care, 11095 Viking Dr., Suite 350, Eden Prairie, MN 55344; (612) 943-9577.

Cost: None

Mutual of Omaha Companies

Mental Health/Substance Abuse Medical Necessity Utilization Review Criteria

Mutual of Omaha Companies' Integrated Behavioral Services has developed five sets of utilization management criteria for mental health/substance abuse treatment services. These criteria are designed to assist in matching patient need, level of functioning, or status with the characteristics of each level of care. The criteria sets are: adult/adolescent mental health 24-hour services, adult/adolescent substance abuse 24-hour services detoxification, adult/adolescent substance abuse 24-hour postdetoxification services, child mental health 24-hour services, and mental health/substance abuse non-24-hour services.

Ordering information: Contact Mutual of Omaha Companies--Integrated Behavioral Services, Mutual of Omaha Plaza, Omaha, NE 68175; (402) 342-7600.

Cost: $49.95

U.S. Behavioral Health

Guidelines for Level of Care Decisions

This document is designed to assist care managers in determining appropriate levels of care for patients with substance use disorders.

Ordering information: Contact Bill Goldman, Senior Vice President for Medical Affairs, U.S. Behavioral Health, 2000 Powell St., Suite 1180, Emeryville, CA 94608-1832; (510) 601-2230.

Cost: None

Value Behavioral Health, Inc.

Clinical Protocol and Procedures Manual, Section D, Adult/Adolescent Substance Abuse (draft)

Patient placement criteria and substance abuse treatment planning guidelines for adults and adolescents are included.

Ordering information: Contact Ian Schaffer, M.D., Executive Vice President and Chief Medical Officer, Value Behavioral Health, Inc., 3110 Fairview Park Drive South, Falls Church, VA 22042; (703) 205-6700.

Cost: None

Managed Care Resources

The Center for Substance Abuse Treatment (CSAT) has developed a variety of reports and other documents to assist States in preparing for healthcare reform and the effects of managed care on the delivery of substance abuse treatment services. Some of them are described below. Other documents and articles that may be helpful are included.

Center for Substance Abuse Treatment

Annotated Bibliography of Managed Care Materials (October 1994)

This bibliography lists useful materials, many of which are free of charge, on topics related to managed care. Sections include: preparing for managed care, needs assessment, performance measures, screening and assessment tools, uniform patient placement and utilization review criteria, peer review, finance, program evaluation, treatment outcomes monitoring systems, and outcomes evaluation.

Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

Cost: None

Some of the materials listed in the annotated bibliography described above include:

- *Managed Care Readiness Guide and Checklist* (1994).

  This checklist identifies strengths and weaknesses in substance abuse provider systems and can be used to facilitate a strategic planning process to assist an organization in preparing to succeed in a managed care environment. The accompanying guide provides suggestions on how to use the checklist and enhance discussion of the critical issues.

  Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

  Cost: None

- *Managed Care and Substance Abuse Treatment: A Need for Dialogue* (September 1992)

This document explores managed care and its relationship to AOD abuse treatment. Sections include: the current fiscal crisis within the healthcare system, the development and expansion of managed care as a key response to the crisis in healthcare, and the critical importance of establishing treatment protocols for different levels of care.

Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

Cost: None

- *Essential Elements and Policy Issues of Contracts for Purchasing Managed Care Service* (December 1994)

  This publication illustrates the processes involved in purchasing, monitoring, and managing managed care services for individuals with alcohol or other drug problems. It is designed to help prepare single State agency (SSA) directors to successfully interface with managed care entities in the context of current healthcare reform.

  Ordering information: Contact David Griffith, Public Health Advisor, Division of State Programs; (301) 443-3820.

  Cost: None

- *Resource Materials on State Health Care Reform* (October 1993)

  This document includes Minnesota's chemical dependency treatment outcome charts; Oregon's cost savings, avoidance, and offsets information; Washington State's economic data; and Vermont's recommended principles of the mental health/substance abuse advisory group on healthcare reform.

  Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

  Cost: None

- *Substance Abuse and Mental Health Benefits in State Health Care Reform: A Review of State Legislation* (October 1993)

  This document presents an analysis of the activities in key States pursuant to healthcare reform legislation affecting substance abuse and mental health treatment.

  Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

  Cost: None

Other Sources on Managed Care

General Accounting Office (GAO)

Health Insurance: How Health Care Reform May Affect State Regulation (November 1993)

This document summarizes results of a survey of States' regulation of health insurance. It examines the portion of the health insurance market currently regulated by State insurance departments, the budget and staff of State insurance departments committed to regulating health insurance, and the key activities insurance departments perform.

Ordering information: Contact Documents Distribution, GAO; (202) 512-6000.

Cost: None

Join Together: A National Resource for Communities Fighting Substance Abuse

Health Reform for Communities: Financing Substance Abuse Services (no date)

This document includes seven recommendations from a national policy panel for ensuring financing for substance abuse services.

Ordering information: Contact Ben Rivers, Join Together, 441 Stuart St., 6th Floor, Boston, MA 02116; (617) 437-1500.

Cost: First copy free; additional copies $1 each

Appendix C—Glossary

American Society of Addiction Medicine (ASAM)—ASAM is an international organization of 3,000 physicians dedicated to improving the treatment of persons with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of **patient placement criteria** that have been widely used and analyzed in the alcohol and other drug (AOD) treatment field.

Assessment—The process of collecting detailed information about a person's alcohol and other drug use, emotional and physical health, family and social problems, roles and supports, educational and employment status, legal status, and other areas as a basis for identifying the appropriate level and intensity of AOD treatment as well as needs for other services.

Assessment tool—See **instrument**.

Biopsychosocial—A holistic approach to assessment and treatment that takes into account a person's medical (biological), psychological, and social needs. This approach reflects the understanding that addiction affects the whole person and is influenced by a wide range of factors.

Block grant—An amount of Federal funds appropriated annually by Congress to be distributed at the State level according to various requirements. Each year, under the Substance Abuse Prevention and Treatment Block Grant, approximately $1.2 billion is appropriated for the Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). CSAT provides these funds to **single State AOD agencies** in each State for distribution to AOD treatment providers, that must meet several categorical requirements, such as ensuring priority treatment for pregnant women.

Bundling—An approach to treatment that ties or "bundles" several treatment services together, often delivering them in a specific treatment **setting**. Because this approach often overlooks a patient's individual needs and can lead to inappropriate and unnecessary service provision, the current trend is toward **unbundling** services, a more flexible approach.

Capitation—The establishment of a fixed amount of payment for services for a discrete number of persons during a specified period of time. It involves shared risk between the payer and provider of care.

Client—An individual receiving AOD abuse treatment. The terms client and **patient** are sometimes used interchangeably, although staff in medical settings more commonly use the term **patient**.

Coalition for National Clinical Criteria—A multidisciplinary group of individuals in private AOD treatment sectors, professional organizations, research, payment, and State and Federal

Government sectors. It was established in November 1992 to assess support for adopting national patient placement criteria and determine methods of gaining the support of others in the treatment field.

Continuum of care—A structure of interlinked treatment modalities and services that is designed so that individuals' changing needs will be met as they move through the treatment and recovery process.

Criteria—See **patient placement criteria.**

Dimension—A term used in the ASAM patient placement criteria to refer to one of six patient problem areas that must be assessed when making placement decisions.

Dual diagnosis—A diagnosis that includes a concurrent substance use disorder(s) and a psychiatric disorder(s).

Eligibility criteria—Factors which determine whether a patient may receive treatment. These include: financial status, insurance coverage, age, severity of illness, geographic location, and whether a patient is a member of a special population.

Employee assistance program (EAP)—A department or organization created or hired by an employer organization to provide its employees with health, mental health, and AOD treatment services or to refer them to other providers.

Healthcare reform—Efforts occurring at the national, State, and local levels to change the delivery of healthcare services to meet three goals: improved access to care, better quality care, and reduced costs—goals that are shared by those seeking to implement uniform patient placement criteria.

Incremental charges—Charges for treatment that start at a fixed rate for core-level treatment, with additional charges for each "unit" of treatment.

Instrument—A measurement tool, usually a questionnaire, that is used for used for gathering information about an individual to aid screening, assessment, diagnosis, and/or clinical decisionmaking.

Intensity of service—The degree or extent to which a treatment or service is provided, which depends on a patient's level of need. Some treatments—for example, medically managed inpatient treatment, are inherently more intensive than other treatments—for example, outpatient treatment or a halfway house. The provision of other services, such as vocational training, can be more or less intense, depending on patient needs. (See **level of care**.)

Level of care—As used in the ASAM criteria, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient. Other levels of care within this range, such as therapeutic communities, have been described in other criteria.

Managed care—An approach to delivering health and mental health services that seeks to improve the cost effectiveness of care (i.e., improved services at reduced cost) by monitoring service seeking and delivery. Methods include managing the overall delivery of care by selecting providers (for example, health maintenance organizations or other provider networks) and managing treatment decisions by individual providers for individual patients (for example, **utilization review**).

Matching—A process of individualizing treatment resources to a patient's needs and preferences based on careful assessment. Matching has been shown to increase treatment retention, and thus improve treatment outcomes. It also improves resource allocation by ensuring that patients receive the appropriate **level of care** and **intensity of services.** (See **continuum of care**, **unbundling**).

Modality—A specific type of treatment (technique, method, or procedure) that is used to relieve symptoms or induce behavior change. Modalities of AOD abuse treatment include, for example, inpatient social milieu treatment, group therapy, and individual AOD counseling.

Needs assessment—A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal. Use of **patient placement criteria** can reveal gaps in the **continuum of care** and can aid in needs assessment at the community and State levels.

Outcomes monitoring—Collection and analysis of data from persons in AOD abuse treatment to determine the effects of treatment, especially in relation to improvements in functioning (treatment outcomes monitoring); the same type of process can be performed at the program level to determine whether programs are meeting their goals (program outcomes monitoring). In publicly supported systems, outcomes monitoring will also help to establish accountability for the expenditure of public funds.

Patient—An individual receiving AOD abuse treatment. The terms client and **patient** are sometimes used interchangeably, although persons in medical settings more commonly use the term **patient**.

Patient placement criteria (PPC)—Standards of, or guidelines for, AOD abuse treatment that describe specific conditions under which patients should be admitted to a particular **level of care** (admission criteria), under which they should continue to remain in that **level of care** (continued stay criteria), and under which they should be discharged or transferred to another level (discharge/transfer criteria). PPC generally describe the settings, staff, and services appropriate to each **level of care** and establish guidelines based on AOD diagnosis and other specific areas of patient assessment.

Placement—Selection of an appropriate level of care, based on assessment of individual needs and preferences.

Private sector—The network of for-profit and not-for-profit AOD abuse treatment agencies, operated primarily with private rather than public funds. In general, treatment in the private

sector is paid for by the patient or by private insurance. Many agencies in the private sector have developed their own **patient placement criteria**.

Public sector—The network of AOD abuse treatment providers supported by public (Federal, State, and local) funds. Within each State, public-sector agencies are overseen by a single State AOD agency that disburses funds. Several States have developed their own **patient placement criteria**.

Rationing—The act of limiting treatment or other services to certain individuals or populations, usually due to limited resources.

Setting—A specific place in which treatment is delivered. Settings for AOD abuse treatment include hospitals, methadone clinics, community mental health centers, and prisons or jails.

Single State AOD agency (SSA)—The agency in each State that functions to establish policies, disburse funds, and provide budget and program oversight for AOD abuse treatment within that State. In addition to State funds, the SSAs disburse funds from the Substance Abuse Prevention and Treatment **Block Grant**.

Third-party payers—Payers for services other than the client or patient who receives the services, including private insurance and public payers such as Medicare and Medicaid.

Unbundling—A approach to treatment that seeks to provide the appropriate combination of specific services to match a patient's needs. The goal of unbundling is to provide an array of options for flexible individualized treatment, which can be delivered in a variety of settings.

Uniform Patient Placement Criteria (UPPC)—A set of **patient placement criteria**, not yet developed, that would provide national standards for assessing and treating patients with AOD abuse disorders and that would be used by all providers in the **public sector** and **private sector.**

Utilization review—A method used in **managed care** approaches in which an outside organization reviews clinical decisions in areas such as hospital admission, length of stay, and discharge, as well as choices regarding **placement** and treatment **modality** in order to improve the quality of care and reduce costs.

Wraparound services—Services in addition to AOD abuse treatment that are provided to patients to improve retention in treatment and treatment outcomes. Example of such services are health and mental health care, childcare, parenting skills training, housing, and educational and vocational training.

Appendix D—Federal Resource Panel

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Exhibit 3-2 Important Aspects of the ASAM Criteria	
Positive Aspects:	**However:**
Developed by consensus	AOD treatment field only partially represented
Widely circulated in the AOD treatment field	Lack of financial support for broad enough distribution
Encourage a broad continuum of care	Some levels of care and treatment modalities not included
Use common language for levels of care	Categorizing levels of care can discourage individualized treatment
Potential for cost savings	Cost savings may not be realized in the "gaps" that exist in the four levels of care
Broad, multidimensional assessment	Currently no reliable way to measure these dimensions
Systems approach simulates expert human thinking	Can be difficult to use
Provide framework for admission, continued stay, and discharge.	May not adequately allow for tapering intensity of treatment.

However, several sets of PPC, both public and private, were impressive in numerous ways and represent improvements to the ASAM PPC and models for future PPC development. A full review, analysis, and discussion of all documents would require work beyond the scope of the consensus panel. Other PPC that were not in the possession of the panel will need review as well. Appendix B includes information about obtaining copies of most of the criteria sets reviewed by the panel.

Public Criteria

Several States have adopted variations of the ASAM criteria to fit their systems. PPC from public treatment systems that were modeled on the ASAM criteria clearly share many of the fundamental strengths and weaknesses of those criteria. However, many States have made significant improvements in the ASAM criteria to make them more appropriate to their systems and easier to use.

Iowa

The developers of the Iowa PPC adapted the ASAM model and developed PPC for other levels of care. A significant contribution of the Iowa criteria is that they include PPC for some levels of care that are missing in many public treatment systems such as halfway houses and longer term residential treatment. The Iowa criteria also provide an excellent glossary. The panel was impressed by both efforts but questioned the description of long-term residential PPC. Two distinct levels of care are described: primary residential treatment (50 hours/week of rehabilitation sessions) and extended residential treatment (30 hours/week of rehabilitation followed by other rehabilitation and community services). The panel workgroup felt the PPC should more clearly define the distinctions between the two levels of care.

Illinois

Illinois is creating a short draft addendum to the ASAM PPC, which was not available to the consensus panel. The goal is to make the ASAM criteria more compatible with publicly funded systems. This goal should be a consideration in any adaptation of ASAM criteria.

Massachusetts

Massachusetts has made a significant contribution by creating a statewide consensus panel to recommend changes to ASAM criteria that reflect the State's unique characteristics. It produced PPC for Level I

(outpatient), Level III (detoxification), youth residential, and methadone treatment. It is worth noting that the ASAM Level IV criteria were used for the foundation of their Level III, with language adapted to better reflect the clients treated in the public system. Each amendment the State made to the ASAM text was footnoted, a procedure worth duplicating by others.

A large managed care company has begun to manage the bulk of the Massachusetts Medicaid population. Using the Massachusetts PPC as a conceptual base for decisionmaking, the company has redirected clients from Level IV hospitals to Level III facilities. When this transition began, 50 percent of detoxification episodes were in Level IV hospital programs. In less than 1 year, this rate has been reduced to less than 10 percent.

Washington

Recent State healthcare reform, which will replace mandated chemical dependency healthcare with case-managed chemical dependency treatment services, has stimulated acceptance of the ASAM criteria as the tool for case management. Efforts are now under way to incorporate

specific reference to the ASAM criteria into healthcare reform efforts. Training in the use of the ASAM criteria is ongoing.

Minnesota

The Minnesota PPC preceded the ASAM criteria and are particularly useful as a resource for future PPC. They are more compact and standardized than the ASAM criteria, making them more likely to be applied consistently, but also making them more arbitrary and rigid. Perhaps the greatest usefulness of the effort to establish criteria in Minnesota is not the criteria themselves, but the lessons learned in the 8 years of experience implementing them.

Private Criteria

Private behavioral health managed care companies are actively taking steps to examine the PPC that they collectively use. They recently formed a Managed Care Coalition on Substance Use Disorders, a subcommittee of the Coalition for National Clinical Criteria, with the goal of creating a unified voice for their services in the healthcare reform environment. In this process, they have shared information that was previously withheld as proprietary and are demonstrating a willingness to explore and support the development of standardized PPC.

It is important to note that, for the most part, the criteria are specifically designed as utilization management tools, indicating the *minimum* requirements for entering a level of care. This approach substantially differs from that of the ASAM PPC, which were not designed as a utilization management tool, but to provide the conceptual framework and specifics for patient placement.

A Comparison of Private Criteria and the ASAM PPC

The panel workgroup reviewed several sets of criteria from private managed care providers and compared them with the ASAM PPC. Generally, the workgroup found that the criteria devised by managed care entities consistently differ from the ASAM PPC. They are more concise and substantially more restrictive regarding access to the intensive levels of care. In addition, they emphasize the distinction between the use of partial hospitalization and intensive outpatient treatment (Level II). They tend to focus on psychiatric factors and often demonstrate less awareness of the unique aspects of substance abuse treatment as compared with other components of their services.

Core Elements of Managed Care PPC

The panel workgroup found many similarities among the sets of criteria developed by managed care companies. They have, in some cases, divided the services designated as Level II services by ASAM into two distinct components: partial hospitalization and intensive outpatient care.

The common core elements of the partial hospitalization level of care include:

- A focus on AOD dependence rather than AOD abuse

- A minimum of 4 to 6 hours per day of services
- Twelve to 20 hours per week of treatment services (clients may or may not receive services every day but get a minimum of 4 to 6 hours of service on treatment days.)
- Provision of nursing staff and appropriate medical services
- Regular access to psychiatric services.

The common core elements of the intensive outpatient level of care include:

- A focus on AOD abuse rather than AOD dependence
- A minimum of 9 hours of treatment services per week
- No requirement for nursing staff, medical services, or frequent psychiatric services.

These systems have been leaders in the development of ambulatory outpatient detoxification services.

The managed care PPC appear to be highly restrictive in terms of permitting any 24-hour level of AOD care. Examples included requiring severe psychiatric problems as a condition of admission or not allowing a readmission to residential treatment if such treatment has been delivered in the last 5 years.

Another TIP in this series, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, documents the clinical viability and utility of the intensive outpatient level of care.

"Restorative Potential"

Some managed care providers use "restorative potential" (the ability and willingness of a client to benefit from treatment) as a factor in deciding level of care. The concept of restorative potential has been used to limit or deny services to clients who are perceived as using treatment services excessively or who have a bad track record of complying with treatment. Some providers use it to assign the client to a less intensive level of care. For the client with a history of relapse problems, a more appropriate clinical approach would be a careful assessment and identification of the barriers to recovery. However, addressing recovery barriers does not absolve patients from responsibility. The appropriate use of restorative potential involves assessment of both external barriers to recovery and the patient's investment in the process. Failure to address specific recovery barriers and match the client to appropriate services and settings only increases the human and financial cost to the client and society.

Interim Recommendations For PPC

For public and private institutions preparing to adopt, write, or amend PPC for their clients with AOD addictions, the consensus panel recommends interim steps until a new set of criteria can be developed. The interim criteria must effectively address the accepted shortcomings of the ASAM PPC and incorporate the best components and aspects of other excellent PPC now available. The panel recommends that:

- The ASAM PPC be used as a baseline document upon which to build
- The Massachusetts and Iowa PPC be used as a basis for adding methadone treatment, adolescent residential treatment, and halfway houses to the ASAM criteria
- Others develop PPC for "missing" settings, services, and modalities consistent with the ASAM style
- Prevention/early intervention be added as a fifth level of care.

A discussion of each of these recommendations is presented in the following sections.

The Coalition for National Clinical Criteria has, in the course of three meetings, discussed the need for modifications to the ASAM criteria. These modifications address many of the same gaps in service identified by the consensus panel workgroup. On September 9, 1994, the coalition voted to proceed with the development of a supplement to the ASAM criteria that substantially addresses the panel's interim recommendations. ASAM has expressed a willingness to fund the publication of this supplement with a projected publication date of June 1995.

ASAM PPC as a Base Document

The ASAM criteria were chosen by the panel as a baseline document for many reasons. Although incomplete and flawed in some respects, they provide the most thorough and systematic model to date for assessing key dimensions of patient need. They systematically link these dimensions with a specified level of care.

- They have been through a more comprehensive formal and informal review process than any other PPC, are the most widely known, have generated the most discussion, and provide the most comprehensive structure (clearly defined levels of care, six dimensions, and admission and continued stay and discharge criteria for both adults and adolescents).
- Although conceptually different criteria of other groups and States have been examined, they have not been found to significantly improve on the ASAM PPC.
- They are the *de facto* base on which many other criteria have been built.
- They have drawn the most interest by researchers.
- The ASAM six-dimensional assessment framework—with clearly defined levels of care and admission, continuing care, and discharge criteria—is a clinically comprehensive model and would most easily be accepted as the best single base document upon which to build across the treatment field.

Massachusetts and Iowa PPC

Additional PPC should be added to the ASAM base document to include levels of care that are widely recognized as missing from the ASAM criteria. Several have been identified that are well developed and consistent with the ASAM PPC methodology.

Systems preparing to incorporate, develop, or revise existing PPC would benefit from studying the following PPC and incorporating portions of them—as is or amended—into their PPC.

These include:

- The Massachusetts PPC for methadone treatment and adolescent residential treatment. These criteria follow ASAM methodology and have already been adopted as an addendum by ASAM. Additionally, their Level III adaptation is probably a better fit for public detoxification programs than the ASAM Level IV.
- Iowa PPC for residential treatment programs. However, these PPC attempt to combine two distinct levels of care—primary residential and extended residential—into a single set of criteria. These two levels of care are actually quite distinct, designed for different purposes, and serve different clinical populations. This model is not yet as clear as it could be. With relatively minor adjustments, these criteria could serve as an excellent base for short-term, more clinically intensive residential treatment and longer term residential programs. It may be wise to separate short-term care from extended care in developing UPPC.

Addressing Gaps in ASAM Levels of Care

In reconceptualizing the level of care model in this interim period, the panel suggests that the four-level system be maintained as an umbrella system under which other more specific criteria and "sublevels" of criteria can be incorporated. The panel suggests the following structure for temporarily organizing multiple levels of care.

Under Level I, Outpatient Treatment, there are currently a wide range of outpatient treatment models used in the AOD treatment field. The ASAM PPC now include outpatient care and methadone treatment, but there is nothing specifically designed for the many other low-intensity treatment models.

Under Level II, Intensive Outpatient Treatment/Partial Hospitalization, there are two distinct types of services in the treatment field, Intensive Outpatient and Partial Hospitalization. While there are no ASAM-type criteria that separate these "sublevels," managed care organizations do have basic admission criteria for them. A review of some of their criteria suggests certain core elements that generally define these two services (described earlier in this chapter). These core elements should be developed into PPC of the ASAM type. In addition, a TIP in this series, entitled *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, describes one approach and a range of services and core components at this level of care.

Under Level III, Medically Monitored Intensive Inpatient Treatment, there are several types of 24-hour residential treatment programs, some of which provide medically monitored detoxification services. These include halfway houses, social detoxification centers, therapeutic communities, extended (low-intensity) residential, and short-term intensive rehabilitation treatment. The ASAM PCC are now available for halfway houses and, with some amendment, short- and long-term residential treatment. They are not currently available for therapeutic communities or social detoxification; with the exception of halfway houses, no criteria seem to adequately characterize 24-hour residential programs.

Level IV, Medically Managed Treatment, requires no division into sublevels. However, as noted earlier, the criteria overstate the need for the hospital level of care in today's treatment environment. Programs are finding they can perform detoxification in various nonhospital inpatient and outpatient settings. Further work needs to be done to update these criteria and determine the most appropriate clients to be detoxified in less intensive inpatient and outpatient

settings without substantial physician involvement. A TIP under development in this series, *Detoxification from Alcohol and Other Drugs*, provides extensive detoxification guidelines for use in a variety of settings, including outpatient settings.

Some have argued that the level-of-care umbrella might be more useful if Level III were redefined as 24-hour Residential Treatment (that may or may not be medically monitored). Under this umbrella, all of the sublevels now under Level III would remain except Level III, Detoxification, which would be recategorized under a new Level IV (24-hour Residential Detoxification). The panel is not recommending this amendment, but the idea may be useful to consider during this interim period.

Prevention/Early Intervention Level

A necessary additional level of care in future PPC development is Prevention/Early Intervention. Many health maintenance organizations (HMOs) and public treatment systems already include prevention as a major part of their budgets, and the prevention system is a key component of certain treatment systems. For instance, HMOs and other capitated/fixed-payment systems of care have financial and clinical incentives to reach out to their served population. They offer preventive education (primary prevention) and identify high-risk individuals, to whom they provide education and intervention (tertiary prevention). They may also provide interventions to minimize the risk of relapse or more expensive treatment at a later time.

In the future, one can expect to see an increasing number of systems with this level of care as well as more attention focused on prevention. Prevention efforts could include training for doctors and other medical personnel, educators, criminal justice workers, and social service providers in the methods for brief but effective interventions that consist of one or a few meetings.

A necessary additional level of care in future PPC development is Prevention/Early Intervention. Criteria in this area would allow a client to enter the treatment system at a prevention level before an acute episode necessitated treatment at a more intensive level.

The prevention level of care could include structured relapse prevention services in Level I (outpatient care). For example, in the current system, access to AOD benefits usually requires a recent episode of AOD abuse. But patients experiencing stress and in danger of relapse may require immediate addiction treatment expertise. When funders exclude access to AOD benefits in these situations, the likelihood of relapse increases, which leads to the costly need for acute care. Criteria in this area would allow a client to enter the treatment system at a prevention level before an acute episode necessitated treatment at a more intensive level.

"Unbundling"

The CSAT consensus panel members were unanimous in their belief that future PPC need to become far less categorized, allowing treatment providers and purchasers to choose the most appropriate combination of setting, treatment, and intensity of services to meet the client's individual needs.

To address the rigidity of the current system, many managed care companies and public treatment systems are now suggesting that treatment modality and intensity be "unbundled" from the treatment setting. Unbundling is a practice that allows any type of clinical service (such as psychiatric consultation) to be delivered in any setting (such as a therapeutic community). With unbundling, the type and intensity of treatment are based on client need and not on limitations imposed by the "category" of care they are in, or whether they are sleeping in a halfway house or hospital. Indeed, a new type of care is emerging that combines partial hospitalization with room and board. The unbundling concept is designed to maximize individualized care and encourage the delivery of necessary treatment in any clinically feasible setting.

Examples of Unbundled Care

There is a pilot program under way in Montana with Blue Cross and Blue Shield that offers reimbursement based on a continuum of service. Blue Cross and Blue Shield offers a $500 benefit for a segment of treatment but does not specify the setting. The treatment can take place in a hotel, halfway house, or during a short-term retreat. Other examples of unbundling include providers who have capitated contacts with managed care companies or other insurers. They have the option and are financially motivated to arrange for a modality of care wherever it is clinically appropriate. This maximizes positive outcomes in the most cost-efficient manner.

The following are hypothetical examples of an unbundled system delivering unique treatment plans that a rigid, categorized system may not easily deliver.

The possibility of an unbundled system delivering a range of levels of care with limited resources is shown in the cases of Mrs. R. and Mr. Q. (see boxes on this page and next). Their options in a system with little flexibility are described first, followed by possible options in an unbundled system.

Hypothetical Example: Mrs. R

Mrs. R is assessed as needing the structure of a scheduled outpatient program (one individual and one group counseling session per week) that allows her to address her rapidly growing cocaine dependency while actively engaging in a daytime job-training program. However, her assessment indicates that she also needs access to a combination of services and settings that may not be accessible in a rigid system of care. Her assessment indicates that:

- She needs a thorough psychiatric evaluation and perhaps medication management that her AOD abuse treatment program does not offer.

- She has two children, no funds to pay a babysitter, and no responsible friend or family member to watch the children.
- She needs transportation, or she will not be able to get to the clinic.
- She lives next to a crack house and acknowledges that she has little chance of maintaining abstinence if she goes home at night. She will not be able to move in with her sister for 3 weeks and needs a place to sleep until then.

In the current categorized treatment system, Mrs. R might be offered the same basic treatment as every other patient, usually one individual and one group counseling session each week. The program may try to refer her to the mental health center across town to get on the waiting list for a psychiatric evaluation, encourage her to try to find someone to provide childcare and transportation, and make her aware of the AA meetings that are held every night. Even the best clinician would have few options to meet this woman's needs.

However, in an unbundled system that tailors the treatment plan and receives payment for its components, the clinician would be able to design a truly individualized treatment plan for Mrs. R. She would receive psychiatric counseling from a psychiatric service that offers a variety of treatment settings. She would be placed in a moderately priced hotel (with which the clinic has developed a business relationship) until she could move. Transportation would be offered by a vendor. A babysitter would be available three nights a week at the clinic and paid for by a separate fund. Mrs. R would have counseling sessions at night to allow her to continue her essential job training.

Unbundling may alleviate some of the problems of providing a continuum of services in rural areas. Using a program that has a recovery house with medical monitoring capabilities and an outpatient program with a case management focus as an example, much of the continuum of care can be covered with two resources.

Hypothetical Example: Mr. Q

Mr. Q. is single. He is stably but marginally employed and lives with friends near a rural population center. He has been referred to the court because of a second offense of driving while intoxicated. He has agreed to referral to an outpatient treatment program, but continues to become intoxicated.

He is then referred to an inpatient program and has a new counselor. Reassessment reveals that Mr. Q has a more extensive drinking problem than first known. He also has serious grief and loss issues and a history of sexual victimization. To meet his many newly identified clinical needs, Mr. Q is referred to an extended care residential program. This requires a move to another facility (perhaps in another town). Once again, he must change counselors.

At the successful completion of his extended care program, Mr. Q is referred to a halfway house to improve his independent living skills and enroll in job training. He is admitted to a different program and assigned to a new counselor.

In an unbundled continuum, Mr. Q would initially participate in assessment and outpatient treatment. When that proves insufficient to meet his needs, he would move into the residential facility, keeping the same counselor. As additional problems become apparent, his treatment plan would change, altering the mix and intensity of services. Although he may receive some services from different team members, his initial counselor would always be available. In some systems, this counselor would act as his case manager; in others, Mr. Q would have an independent case manager assigned to him. As he resolves some of his issues, his treatment plan would continue to change.

Ultimately, the services would be focused on independent living skills. Mr. Q. would not have to move from one facility to another, nor would he have to fail at one level of care to obtain the next.

Treatment Campuses

An example of a setting in which unbundled treatment might be easily delivered is a large treatment campus that has a variety of services available at one site. This campus might include a hospital-based addiction program with a methadone clinic, a day and evening structured outpatient program, a psychiatrist, childcare and transportation services, and a low-cost residential setting. Clients would easily receive an individualized treatment plan that would specify the appropriate frequency, intensity, and type of treatment services. Clients would move from one treatment modality and setting to another, based on assessment of their immediate needs rather than on some categorized, preset time schedule.

Another example is a halfway house that might minimally require a 24-hour setting with possibly 5 hours of group counseling per week. However, a particular halfway house might have a licensed practical nurse on staff 20 hours a week to provide medical services and a psychiatrist or other mental health clinician who visits the program once a week. Additionally, this program might offer transportation to employment and other treatment services. The purchaser might pay $50 per day for the minimum core halfway house service and a specified additional amount for the nursing, psychiatric, and transportation services.

Additional Services

Other examples of services and modalities that might be provided in an unbundled system to supplement minimum core services might include child care, onsite or community-based case management, overnight accommodations or sleeping quarters with or without supervision, psychiatric evaluation and medication management, ambulatory detoxification capability, nursing coverage, mental health professional staff coverage, specialized ethnic and cultural capabilities, and high-intensity clinical programming. A treatment provider would create a menu of services offered with the unit cost of each. This cost would either be billed to the appropriate agency or agencies or monitored in a *capitated* arrangement (as described below).

If patient placement criteria are designed to address both categorized and unbundled treatment, they will contribute to the most clinically appropriate and cost-effective care possible.

Paying for Unbundled Treatment

Two methods of payment are most likely for unbundled services.

Incremental charges. There would be a charge for core-level treatment, and each incremental "unit" of treatment or service.

Capitation. The other main option is *capitation*, the establishment of a fixed amount of payment for services for an individual client during a specified period. There is wide variety in the way capitation principles are carried out in different localities. The basic principles used in a capitation method of paying for AOD treatment include:

- Treatment providers receive a fixed amount of payment per patient for a specified period such as a month or a year, sharing in the financial risk if the patient is either under- or overtreated.
- Clinical providers make decisions about treatment or, in some localities, case management programs assume primary decisionmaking responsibility for patients and coordinate all care among multisystems.
- Clinical providers have flexibility for individual management of the patient.
- Effective monitoring of financial impact, access to treatment, and treatment outcome evaluation are included.

It is important that capitation include money for nontreatment services (such as hotel, childcare, and increased case management costs) that are required to support clients who need such services. Future developments in UPPC that include capitation should incorporate financial incentives that encourage quality care, cost effectiveness, and outcomes-based management with strong monitoring of access and quality of treatment.

Challenges of Unbundling

There are several challenges that must be faced in the development of UPPC that unbundle modalities and intensity of care from the setting:

- Fragmentation of services could occur. It is essential to have clear clinical accountability and careful monitoring to ensure that a client's care is carefully coordinated and managed.
- The potential exists for too much complexity in purchasing, contracting, and measuring performance.
- Licensing regulations may pose a problem for unbundling since these regulations by their nature are relatively arbitrary and rigid. Their customary purpose is to define and set clear minimum standards of care. The flexibility that will be necessary in new treatment practices will require new ways of licensing programs.
- Confusion in reimbursement may result during the shift to clinically driven treatment plans from those that are more program driven. Adjustments must be made in reimbursement methods to accommodate flexibility and unbundling of services.

Unbundling of services need not mean that separate services are provided in separate locations. Unbundled treatment may be available as a program offering a menu of services provided in a single location, from which the client and case manager can choose.

Essential to unbundling is the idea that a standard course of treatment can be separated into its component parts, and that those parts can be provided independently of each other in the necessary level of intensity and duration.

While all current criteria—including the ASAM criteria—are categorized systems and thus somewhat limited in their flexibility, it would be a mistake to abandon them and leap immediately to an unbundled system. An essential interim step is to do a better job of defining categorized levels and establishing widely accepted PPC for each level. The refined categorized levels could be seen as stepping stones to unbundling, which will probably occur very gradually and will need thoughtful development.

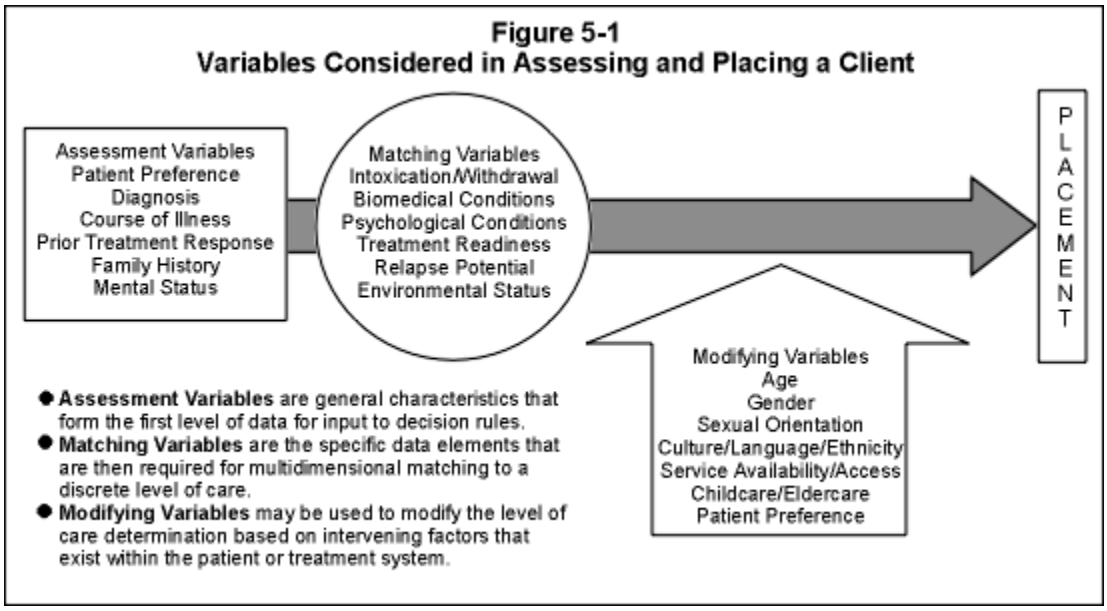
Recommended Characteristics of Uniform Criteria

While PPC play an important role in matching placements to cost-conscious, effective treatment, current models of PPC need improvement to better match patients to specific modalities, not just to a level of care.

Both payers and providers may accept uniform patient placement criteria, assuming those criteria:

- Accurately describe their levels of care
- Have validity regarding recommended placement level
- Are easy to use in real-time clinical decisionmaking
- Include reliable and objective tools and language
- Encourage positive treatment outcomes in the least restrictive environment.

Without uniformity, there are no common definitions of care, no common language, and no capacity to effectively perform and compare the essential research.



Public and private developers of patient placement criteria have recognized this fact by placing assessment at the core of their criteria. All those involved in implementing UPPC should understand the central importance of assessment and its place in AOD abuse treatment. Many Treatment Improvement Protocols (TIPs) in this series describe assessment and related issues. Three TIPs address assessment of special populations—*Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, *Assessment and Treatment Planning of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*, and *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*. The TIP *Matching Patient Needs in Opioid Substitution Therapy* (in development) has a chapter on conducting ongoing assessments during methadone treatment to match patients with needed wraparound services. The TIP *Screening for Alcohol and Other Drug Abuse Among Hospitalized Trauma Patients* (in development) discusses the importance of careful AOD assessment in preventing devastating injuries.

The Center for Substance Abuse Treatment has noted that the following elements, consistent with the biopsychosocial perspective, should be included in a model assessment:

- Medical examination
- Alcohol and other drug use history
- Psychosocial evaluation
- Psychiatric evaluation (where warranted)
- Review of socioeconomic factors
- Review of eligibility for public health, welfare, employment, and educational assistance programs.

There are two basic (and sometimes overlapping) goals of assessment: to determine patient placement, and to determine an appropriate treatment plan. There are important distinctions

between assessment and the concept of PPC discussed in this TIP. Assessment is an individualized process. PPC describe gross characteristics that lead to a recommendation for a level of care. Once a placement decision is made, the PPC serve as a foundation for individualized treatment planning.

As shown in Figure 5-1, patient placement is based on a process of assessment that considers three sets of variables: assessment variables, matching variables, and modifying variables. Using patient placement criteria, the clinician moves from the most general information about the patient and the patient's addiction through a set of variables that match the patient to a discrete level of care to a set of intervening variables that may modify the level of care determination.

Assessment is an ongoing, cumulative process that can provide certification to authorize certain levels of care, particularly if reimbursement is to come from a private entity. As a patient moves from one level of care to another, one assessment builds on another, leading to a discharge plan. Again, a number of different models exist for these phases of assessment, and the addition of managed care to the equation has meant a rapidly changing landscape in this regard.

This TIP panel believes that there is room for a variety of assessment models among the various States and AOD treatment systems. These can range from decentralized, provider-driven models to the central intake and assessment agencies that some States have set up. One model of the decentralized form of assessment is the Target Cities program, which provides services to populations in metropolitan areas at greatest risk for AOD addiction. The program has at its core comprehensive independent assessment evaluation from treatment providers, including physical examinations, psychological testing, and placement criteria.

Each State must evaluate its own needs to determine how resources can best be used in the assessment process. This evaluation process is related to the issue of building organized systems of care, a critical issue in healthcare reform.

Urban systems handling large numbers of patients are likely to have more comprehensive assessment systems than smaller rural systems, which may depend on informal evaluations by public health or criminal justice personnel to place patients in treatment.

Staffing and Training Considerations for Assessors

Because of the increasing complexity of patient profiles, assessments are best performed by professionals highly trained in comprehensive evaluation. Unfortunately, AOD treatment is a profession with a high rate of personnel turnover, particularly in the public sector, where intake workers may be relatively inexperienced. In many systems, the least skilled personnel do assessments, while more highly trained clinicians resist intake work.

When UPPC are being implemented, it will be necessary for intake and assessment workers to be thoroughly trained in the use of the criteria. While the training of these personnel may be the highest priority, all staff must be trained. This will ensure that the benefits of continued stay criteria and individualized treatment planning are realized.

The training must include:

- Information on the benefits of UPPC, both for the delivery system and for individualized patient care
- Specific skills in assessment, the application of placement criteria, and documentation
- Emphasis on the important role of clinical judgment in assessment
- Assessment and placement issues for special populations.

To some degree, the nature of training will depend on the methods by which UPPC are being implemented and the qualifications of the assessors. For instance, if the professionals given the responsibility for assessing and making placement decisions are credentialed AOD counselors who are already doing assessments, the training could focus on the specific placement criteria. For corrections department, human services, or mental health professionals who are inexperienced assessors, the training may include discussion of the nature of AOD use and the treatment delivery systems, as well as the placement criteria. Each State, depending on its resources and implementation plan, must set the specific minimum education, experience, and training requirements for assessors.

When implementing a new public policy that requires significant training, the States can expect to underwrite a substantial portion of the cost. Training will probably be the most expensive aspect of UPPC implementation. It is also true that programs and individual professionals have a responsibility for continuing education. Existing program budgets for training of personnel can defray some of the expense.

Strengths and Weaknesses of the Settings in Which Assessment Occurs

The essential question in choosing the setting for placement decisions is whether to rely on AOD treatment providers or to use agencies with some degree of separateness from the treatment provider. The decision must be made on a State level, based on knowledge of the treatment community and the availability and accessibility of the resources.

The primary arguments for independent assessment is concern about AOD providers having a conflict of interest and the likelihood that the independent assessor can draw on a wider variety of treatment programs.

The primary argument for relying on treatment providers for assessment is continuity of care. Assessments can be more readily linked to individual treatment plans. If assessment information from an independent assessor is not relayed to the treatment provider quickly, the client may have to undergo another assessment.

Many States will find that mixing and matching assessment settings will best meet their needs. A State may, for example, prefer that detoxification programs perform assessments, but many localities have no such dedicated programs. Therefore, this State may permit local social service or public health agencies to perform assessments.

Regardless of the setting(s) chosen, individual clinicians may prefer to refer patients to programs or treatment modalities with which they are well acquainted. The existence of UPPC may not necessarily avoid this dilemma. Ongoing technical assistance, monitoring, and treatment review will be necessary to ensure consistent implementation of assessment and placement standards.

Treatment Programs

An important strength of treatment programs as a setting for the assessment process are the qualified addiction treatment professionals on staff who can learn to use UPPC. In addition, the treatment provider is often sensitive to cultural and local community issues. Another advantage of conducting assessments in treatment programs is that less duplication of effort occurs in treatment than when separate entities perform assessments, as the information obtained can be used immediately for treatment planning.

However, these strengths have parallel weaknesses. Some programs may not have staff members who can deal with issues of cultural sensitivity or the concerns of special populations. Less comprehensive treatment programs will have less comprehensive resources to lend to assessment.

A major problem with assessments performed by treatment programs is the possibility of conflict of interest. Placement decisions may have implications for a program's success in filling its treatment slots. Also, in organizations that offer multiple levels of care, there may be a temptation to place patients at the most expensive level. While professional substance abuse personnel can be expected to make placement decisions based on best practice and the patient's best interest, these can be compelling pressures, particularly in the current atmosphere of financial uncertainty.

The impact of these issues can be minimized by individual programs establishing—and using—internal policies and procedures in which the expectation is that client assessment will determine placement. Providers can then establish internal quality improvement indicators to evaluate the appropriateness of placement decisions. There are already parallels to this with the "at risk" managed care organizations and capitated contracts.

Detoxification Services

Detoxification services have a unique opportunity to identify individuals who need AOD abuse treatment. Many persons who eventually receive AOD treatment are first screened and assessed when undergoing detoxification from alcohol or other drugs. Detoxification service sites may also be used as assessment sites for anyone needing AOD treatment. One advantage is that those who are in danger of or experiencing severe withdrawal, for which specific detoxification services are clinically indicated, can receive an immediate referral. (Another TIP in this series, currently in development, is *Detoxification From Alcohol and Other Drugs*, which provides a detailed examination of detoxification services.)

A body of AOD abuse treatment literature has found that the assessment process should occur at the first intervention point. This is another advantage of performing assessment while a person is

receiving detoxification services. During this period, the individual may engage in self-evaluation and reexperience feelings of crisis, leading to an appreciation of the seriousness of the AOD problem. This can be considered a "teachable moment."

There are some drawbacks in performing assessments at sites that provide detoxification services. First, rural areas often lack dedicated detoxification centers. Second, across the country, many detoxification services are provided in acute care hospitals. Many of these hospitals do not have staff who are trained in AOD assessment or treatment and many physicians lack sufficient training to adequately assess their addicted patients' needs. Third, many people who need AOD treatment do not enter the system through a detoxification center. Some receive detoxification in outpatient settings. Whether or not detoxification settings can perform assessments depends on staffing and other resources.

Managed Care Organizations

Managed care organizations may have a role in assessment in several different models. An example is an organization that manages an employee assistance program (EAP) for a business, performing initial assessments and referring for treatment.

Some managed care organizations do not have face-to-face contact with patients. Involving these organizations in the assessment process can provide this contact between the patient and the organization, a human element that is often missing in the managed care environment. A weakness of this model is that most managed care organizations are not licensed for substance abuse programs.

Some managed care providers have, or contract for, trained staff to perform assessments. This approach may have some disadvantages, as the involvement of more personnel contributes to the separation of assessment and treatment planning. This problem is avoided by managed care providers who not only have trained assessment staff, but also operate their own treatment centers.

A major weakness in using managed care providers as the primary assessment resource is that they, like treatment providers, may have a conflict in that they have an interest in placing the patient in the least expensive, least intensive level of care.

Public Funders and Agencies

In some States where most providers of services are private, assessment may be the primary role of the public sector. The underlying philosophy of this approach is that assessment and oversight are where the public interest is preserved, while the State removes itself from the actual provision of services.

A major advantage of this assessment model is that it reduces the potential for conflict of interest. When public agencies are involved, the process is open to public examination and input.

Assessments may be done at agencies such as departments of public health, mental health, social services, and criminal or juvenile justice. Since criminal and juvenile justice personnel have many clients who need AOD treatment, it may be appropriate for such agencies to perform assessments, as they are often familiar with the patient's history and have a sound basis for their treatment recommendations.

Assessments for public clients in Minnesota are provided by county social service agencies and American Indian tribal alcohol and substance abuse programs. Each has specially trained assessors. Assessments are accepted from treatment providers only when the provider has specific expertise in working with a special population or when the county agency is too small to have a trained assessor. When an assessment is performed by a treatment provider, the placement decision is reviewed by the county.

The Target Cities programs provide another model for using an independent assessment model for public clients. A strength of this approach is that assessors are not invested in placement and have little conflict of interest. It also offers an easy point of access into the AOD treatment system. Assessors are specialists in assessment, ensuring that assessments will be performed consistently, systemwide. Assessment by independent agencies may simplify the task of collecting aggregate data.

A weakness to this approach is that when agencies such as mental health and criminal justice become involved in assessment, there can be disagreement about priorities, the process can become unfocused, and fragmentation and inconsistency of services can result. Strong interagency agreements specifying the responsibilities of each agency are essential to coordinating services. Oversight and review are necessary to ensure adherence to standards.

A second disadvantage of this public sector approach is the deterrent effect for some patients because of the association with the enforcement side of government. For example, some women may not want to become involved with a State assessor because they fear their children will be taken away from them once their AOD abuse is known. This critical obstacle prevents some women from seeking or entering treatment. Likewise, fear of incarceration may keep people from revealing information about illicit drug use to a State assessor. In these situations, it is crucial to strictly comply with Federal confidentiality regulations.

Another weakness is the potential duplication of services and the fact that assessment by independent agencies may add another provider to the process. Each additional provider means something else to fund. It is also another potential drop-out point for the patient. Reliance on agencies that are not primarily AOD treatment providers has major implications for staffing in those agencies and for the State's training plan.

Assessment Instruments and Tools

Most current assessment tools do not relate directly to patient placement decisions. Adoption of uniform patient placement criteria will probably lead to the development of more instruments that match agreed-upon assessment dimensions.

A few tools are under development, but they must go through the rigors of reliability and validity testing before they can be used on a widespread basis. Tools should be readily usable by professional staff, providing semiquantitative results that match the various dimensions of the PPC, and should be available in different languages. Automated tools facilitate data collection, ease of administration, and transfer of information in a system. Data from assessment tools should link to treatment outcomes.

Ideally, an instrument should involve a patient interview. The use of an instrument should not be seen as a substitute for the patient interview, which should validate the findings of the instrument. If an assessor focuses wholly on the instrument, it will limit the scope of information obtained.

Some instruments exist that correspond with specific PPC. For example, the Clinical Institute Withdrawal Assessment for Alcohol—Revised (CIWA-Ar) is useful to measure Dimension 1, acute intoxication and/or withdrawal potential as described in the ASAM PPC. For Dimension 2, biomedical conditions and complications, there are no quantitative scales, although the Addiction Severity Index (ASI) does have a medical category. A medical history, a physical examination, and laboratory tests provide the best information to measure this dimension, and special attention should be paid to physical conditions associated with AOD use, such as liver disease or HIV disease.

Dimension 3 addresses emotional/behavioral conditions or complications, which can be measured by the psychiatric or psychological scales on the ASI. There are a variety of psychiatric diagnostic and severity scales, many of which provide useful information but none of which correlate directly with the ASAM PPC.

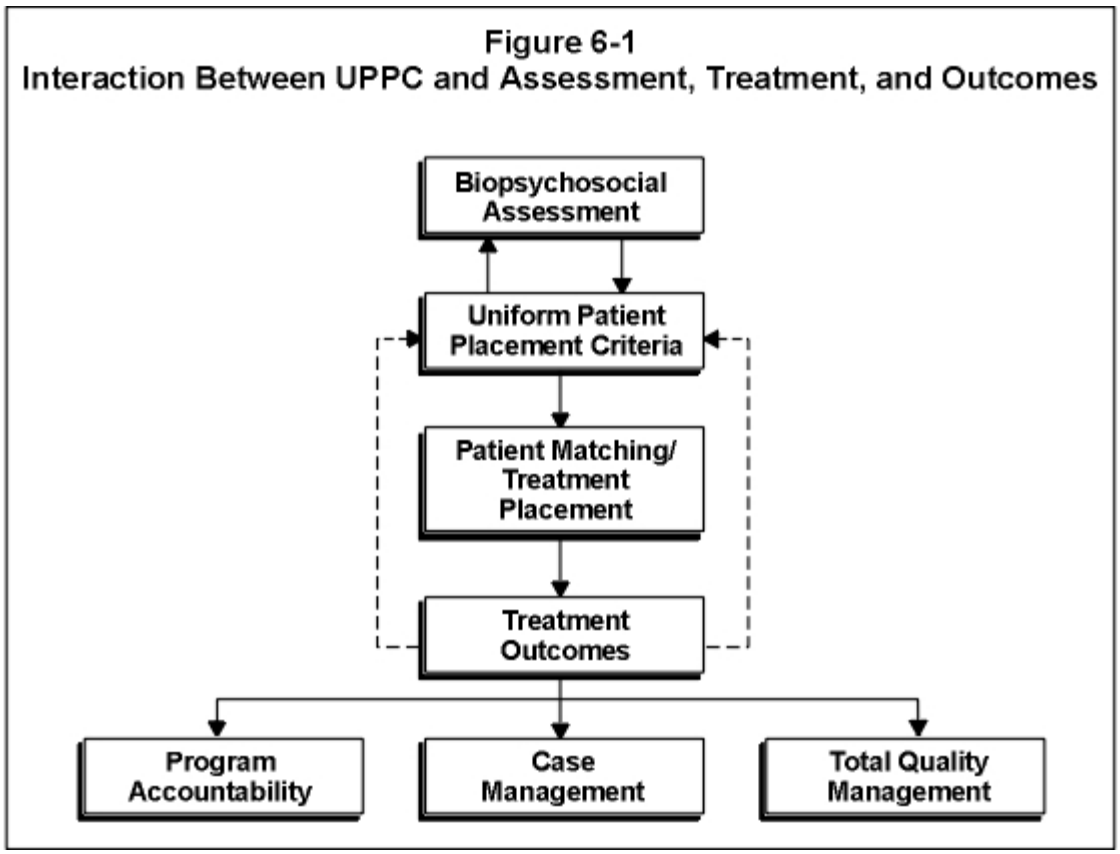
There are only a handful of instruments that measure Dimension 4, treatment acceptance/resistance; Dimension 5, relapse potential; or Dimension 6, recovery environment. Some existing tools include the ASI, the Level of Care Index (LOCI), and the Recovery Attitude and Treatment Evaluator (RAATE). More information on these and other assessment instruments is included in Appendix B of this TIP. The other TIPs on assessment mentioned at the beginning of this section describe a variety of useful instruments.

Summary

A number of important considerations must be examined when discussing implemention of UPPC. Some of these issues include:

- Tying UPPC to licensing requirements and funding sources
- The relationship between UPPC and the actual range and availability of treatment resources
- Wraparound services
- Factors that should be addressed for special populations
- Possible conflicts of eligibility requirements with UPPC
- Elements and goals of assessment

- Staff and training needs for assessors
- Strengths and weaknesses of various settings for assessments
- Assessment instruments and tools.



Researchers will be able to focus on and compare specific samples and subsamples of patients with a similar severity of illness and with specific needs profiles. It is universally agreed that making comparisons between more carefully described samples leads to more valid results.

For example, a group of patients with a particular needs profile, such as single adolescent mothers with a defined severity of illness and specific assessed needs for certain social supports, will be assigned to a particular level of care with a core set of treatment modalities. Researchers can then evaluate differences in their treatment outcomes, which may identify other factors that need to be addressed. For example, it may be found that differences in interpersonal functioning may greatly affect outcome. One subgroup of adolescent mothers with significant deficits in interpersonal skills may have notably poorer treatment outcomes (as measured, for example, by a greater number of or more severe relapses) than a comparable subgroup with good interpersonal skills. AOD treatment services that address these deficits may be found to improve treatment outcomes as well as cost effectiveness of services (as measured by fewer inpatient episodes or reduced need for costly have found themselves withintensive services).

These research findings can be fed back into the process of reviewing criteria (dotted lines in Figure 6-1). New research may address the question of interpersonal functioning and its importance in the initial biopsychosocial assessment. Research may subsequently lead to the specific inclusion of this dimension in the UPPC. Many programs and providers will not have to wait for the published results of empirical research to perceive that certain placements and

services for certain subgroups of patients are not as effective as expected, and they will develop new services to meet those needs.

The role of UPPC in quality improvement and program accountability is clear. The advantages that the criteria give to researchers, they give also to programs and systems. This results in more effective outcome monitoring and program and service evaluation. In effect, implementation of UPPC can help establish the self-correcting system that is the foundation for total quality management (TQM) (Walton, 1990). TQM is a focused management philosophy for providing the leadership, training, and motivation to continuously improve an organization's operations. For a more detailed description of TQM in an AOD treatment setting, see the TIP in this series, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.*

The Role of UPPC in Healthcare Reform

At the time of this TIP's development, legislators and policymakers were engaged in the process of reforming the healthcare delivery system. The goals of uniform patient placement criteria and those of healthcare reform are the same: improved quality of care, greater access to care, and reduced costs. Both healthcare reform and UPPC place a major emphasis on outcome evaluation. It is essential that both groups—those working toward reform and those working toward consensus building around UPPC—recognize that their goals are shared, or they will be working at cross-purposes.

The benefits sets proposed as a part of healthcare reform have included standard limits on AOD treatment. These limits are specified as a fixed number of days or hours of service or number of treatment admissions over a given period of time. UPPC could lay the groundwork for legislators to address AOD treatment in the same manner as other health problems, rather than impose arbitrary cost or time limitations.

A national benefits package for AOD treatment that does not recognize the provisions for levels of care and treatment components laid out in the criteria will render the criteria useless. It is important that those who develop UPPC take into account the current realities of the healthcare environment. There is a need for close collaboration between UPPC and healthcare reform efforts. Criteria should help define the parameters of reimbursable services.

However, the reality is that these groups, which are united in principle, have had very little interaction. The proposed benefits packages that have included AOD treatment and that have been discussed in the national arena have not mentioned UPPC. Early versions of healthcare reform plans focused on service units and on limiting coverage according to units used. Defining care according to limited amounts is not within the spirit of UPPC—or even within the recognized realities of treatment outcomes. For example, in one study, a quarter of those who had successfully completed treatment (defined as 1 year of sobriety) had exceeded the limit on units of treatment, according to one of the healthcare reform proposals (NSI Congressional Briefing, 1994). Studies have shown that a minimum of 3 to 6 months of continuing care is critical to recovery (Hoffmann and Miller, 1992). A benefits package that limits care short of

critical thresholds does not recognize the importance of a continuum of care and will not serve the needs of patients. Those who are currently involved in efforts to build consensus around UPPC have not created a strong enough constituency to have political consequence at the level that healthcare reform is now being addressed.

The advantage of using UPPC as unifying treatment structure is that the criteria can work within any healthcare reform plan. For example, if research finds that 35 percent of those who require a certain level of care are not receiving it, then the data can be used to change funding mechanisms and make reform efforts more responsive to clinical realities.

If criteria are part of the reformed healthcare delivery system, they will work toward ensuring equal access to treatment. Based on the criteria, patients with similar needs will be placed in the same level of care and will receive similar services. They will work toward making some services available to most people—a significant step in ensuring equal access to care.

Rationing

The rationing of treatment services is not widely discussed, but it does occur. Many discussions about the topic portray managed care organizations as the culprit because they sometimes do not authorize the level of care, frequency, or length of care that is requested. In fact, healthcare services are rationed in other ways that have similar effects on those needing AOD abuse treatment.

For example, in the AOD abuse treatment field, rationing occurs in the sense that those who have private insurance or financial resources to pay for their care generally experience fewer impediments to receiving treatment than those who are uninsured or underinsured. Those who have Federal Medical Assistance or Medicare traditionally have had access to care, although primarily in the public system. Those lacking insurance or sufficient income have depended primarily on the public system to provide their AOD treatment services. Those with some income but without insurance (either because they have no policy or because the policy does not cover AOD treatment services) have found themselves with little access to care in either the private or the public system. When the public system is overloaded, another kind of rationing occurs because the number of treatment slots does not meet the demand for treatment. In fact, most insurance of any description has limitations on the type of service, the number of visits, or the amount of payment it will provide for AOD abuse treatment.

Thus, rationing occurs among both managed care organizations and AOD treatment programs and providers. Public policy also plays a role when it establishes eligibility criteria for publicly funded programs and identifies target populations for service priority. While such decisions may be necessary because of the scarcity and lack of access to sufficient treatment resources for the affected populations, the end result is that care is rationed.

UPPC cannot solve the dilemmas posed by these circumstances. However, when UPPC are linked with healthcare reform, with the overall needs of individual clients, and with responsive public policy, they have the potential to provide a reasonable basis for decisionmaking about the placement and range of AOD treatment services necessary for an individual.

Summary

UPPC will help to shape the direction of the AOD treatment field on a national level. Therefore, it is important to reach reasonable consensus within the field on the strengths and weaknesses of existing criteria sets in order to move forward. More empirical evidence is needed to demonstrate that uniform criteria can accomplish expected goals. The panel recommends the formation of a national advisory panel while research is continuing. The panel could guide the consensus-building and implementation process and play a continuing role in the refinement of UPPC.

The use of UPPC will greatly increase the ability of investigators to design and carry out the types of careful studies that are needed to demonstrate the effectiveness of AOD abuse treatment.